HOSPITAL CARE FOR ELIGIBLE VETERANS IN SOUTH ALABAMA

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST SESSION

MARCH 15, 1985

Printed for the use of the Committee on Veterans' Affairs

Ser. No. 99–7

U.S. GOVERNMENT PRINTING OFFICE
47-660 O WASHINGTON : 1985

H761-21.

COMMITTEE ON VETERANS' AFFAIRS

G.V. (SONNY) MONTGOMERY, Mississippi, *Chairman*

DON EDWARDS, California
BOB EDGAR, Pennsylvania
SAM B. HALL, JR., Texas
DOUGLAS APPLEGATE, Ohio
RICHARD C. SHELBY, Alabama
DAN MICA, Florida
THOMAS A. DASCHLE, South Dakota
WAYNE DOWDY, Mississippi
LANE EVANS, Illinois
MARCY KAPTUR, Ohio
ALAN B. MOLLOHAN, West Virginia
TIMOTHY J. PENNY, Minnesota
HARLEY O. STAGGERS, JR., West Virginia
J. ROY ROWLAND, Georgia
JOHN BRYANT, Texas
JAMES J. FLORIO, New Jersey
KENNETH J. GRAY, Illinois
PAUL E. KANJORSKI, Pennsylvania
TOMMY F. ROBINSON, Arkansas
JOHN PAUL HAMMERSCHMIDT, Arkansas
CHALMERS P. WYLIE, Ohio
ELWOOD HILLIS, Indiana
GERALD B.H. SOLOMON, New York
BOB McEWEN, Ohio
CHRISTOPHER H. SMITH, New Jersey
DAN BURTON, Indiana
DON SUNDQUIST, Tennessee
MICHAEL BILIRAKIS, Florida
NANCY LEE JOHNSON, Connecticut
GUY V. MOLINARI, New York
THOMAS J. RIDGE, Pennsylvania
WILLIAM M. HENDON, North Carolina
JOHN G. ROWLAND, Connecticut

MACK FLEMING, *Chief Counsel and Staff Director*

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

BOB EDGAR, Pennsylvania, *Chairman*

DAN MICA, Florida
WAYNE DOWDY, Mississippi
LANE EVANS, Illinois
MARCY KAPTUR, Ohio
ALAN B. MOLLOHAN, West Virginia
TIMOTHY J. PENNY, Minnesota
HARLEY O. STAGGERS, JR., West Virginia
J. ROY ROWLAND, Georgia
JOHN BRYANT, Texas
JAMES J. FLORIO, New Jersey
PAUL E. KANJORSKI, Pennsylvania
TOMMY F. ROBINSON, Arkansas
RICHARD C. SHELBY, Alabama
THOMAS A. DASCHLE, South Dakota
JOHN PAUL HAMMERSCHMIDT, Arkansas
ELWOOD HILLIS, Indiana
GERALD B.H. SOLOMON, New York
BOB McEWEN, Ohio
CHRISTOPHER H. SMITH, New Jersey
MICHAEL BILIRAKIS, Florida
NANCY LEE JOHNSON, Connecticut
GUY V. MOLINARI, New York
THOMAS J. RIDGE, Pennsylvania
WILLIAM M. HENDON, North Carolina
JOHN G. ROWLAND, Connecticut

CONTENTS

MARCH 15, 1985

Page

Hospital Care for Eligible Veterans in South Alabama 1

STATEMENTS OF COMMITTEE MEMBERS

Chairman Shelby 1
Hon. Wayne Dowdy 3
Hon. Alan B. Mollohan 4

WITNESSES

Bedsole, Hon. Ann, member, Alabama State Senate 27
Prepared Statement of Senator Bedsole 165
Bosarge, Robert, Buddy Poppy Committee chairman, Department of Alabama, Veterans of Foreign Wars 35
Prepared Statement of Mr. Bosarge 205
Callahan, Hon. H.L. "Sonny," a Representative in Congress from the State of Alabama 5
Carter, David, executive director, Northwest Florida/Big Ben Health Council .. 43
Prepared Statement of Mr. Carter 273
Cox, Clyde, assistant dean, School of Medicine, University of Alabama at Birmingham, appearing on behalf of Jim Pittman, dean, School of Medicine, University of Alabama at Birmingham 25
Prepared Statement of Dean Pittman 135
Crawford, Dr. Stanley E., dean and vice president for medical affairs, University of South Alabama 25
Edward, Jack, former Member of Congress from the State of Alabama 8
Hearin, William J., publisher, Mobile Press Register 28
Hixon, Jim H., assistant service officer, Bay County, Florida Veterans' Service Office 45
Jackson, James, senior vice commander, Fourth District, Department of Alabama, Disabled American Veterans 35
Prepared Statement of Mr. Jackson 217
Knepper, Randy, on behalf of Hon. Earl Hutto, a Representative in Congress from the State of Florida 40
Prepared Statement of Congressman Hutto 254
McDonald, Harry, commander, Department of Florida Disabled American Veterans 43
Mims, Hon. Lambert C., mayor, city of Mobile, AL 6
Payne, Robert, district 9, Department of Alabama, Veterans of Foreign Wars .. 37
Smith, Hon. John, mayor, city of Pritchard, AL 7
Stover, Simon F., director of Veterans' Affairs, State of Florida 40
Prepared Statement of Mr. Stover 266
Sullivan, Dr. Daniel F., chairman, Health Committee, Mobile Area Chamber of Commerce 29
Thompson, Donald, Director, Southeastern Region Department of Medicine and Surgery, Veterans' Administration 10
Prepared Statement of Mr. Thompson 124
Tyson, John, commander, Department of Alabama, the American Legion 32
Wallace, Hon. George C., Governor, State of Alabama 22
Prepared Statement of Governor Wallace 132
Whiddon, Dr. Frederick, president, University of South Alabama 20

Page

Wilkes, Frank D., Director, Alabama Department of Veterans' Affairs 30
Prepared Statement of Mr. Wilkes 168

MATERIAL SUBMITTED FOR THE RECORD

Articles:
"Caring for the Older Veteran," by Administrator Harry N. Walters, Veterans' Administration 192
"Demand for Care Exceeds VA Resources," American Medical News 201
Statements:
Association of American Medical Colleges 152
Heflin, Hon. Howell, a U.S. Senator from the State of Alabama 122
Associated General Contractors of America 281
Kilborn, Vincent F., attorney-at-law, Mobile, AL 237
Mason, James L., president, Mobile County Commission 243
Veterans Hospital Committee 222
Bertran, Bill, commander, AMVETS Post 78, Niceville, FL 258
Simpson, Hon. Alan K., chairman, Senate Committee on Veterans' Affairs 276
Temme, M.G., mayor, city of Bayou La Batre 204
Hawkins, Hon. Paula, a U.S. Senator from the State of Florida 278
Resolution:
American Legion, Department of Alabama, endorses purchase of Providence Hospital, Mobile, AL, to be converted into a Veterans' Administration hospital 242
Reports:
Site visit to Providence Hospital, Mobile, AL, by Mr. Ralph Casteel staff member, House Committee on Veterans' Affairs 47
"Final Report on Future Bed Need and Potential Sites for New VA Hospitals in Florida," submitted by Veterans' Administration 51
"Report of Visit, Providence Hospital, Mobile, AL, submitted by Robert L. Neary, Jr., Director, Facility Planning Service, Department of Medicine and Surgery, Veterans' Administration 113
"Criticism of Preliminary MEDIPP Study on Providence Hospital," submitted by Dr. James A. Pittman, dean, University of Alabama, School of Medicine 174
Summary 189
"Caring for the Older Veteran," submitted by the Veterans' Administration 192

HOSPITAL CARE FOR ELIGIBLE VETERANS IN SOUTH ALABAMA

FRIDAY, MARCH 15, 1985

HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
Mobile, AL.

The subcommittee met, pursuant to notice, at 10 a.m., in Courtroom No. 1, U.S. Courthouse, 113 St. Joseph Street, Mobile, AL, Hon. Richard Shelby, presiding.

Present: Representatives Shelby, Mollohan, and Dowdy.

Mr. SHELBY. The committee will come to order.

There are some seats up here on my left and there are a lot of seats over here in the jury box. I am sure some of you had rather be in the jury box than in the dock down here. I know I would. Please, all come in. The sooner we settle down, the sooner we can start. We have a lot of witnesses this morning and we are going to have to move quickly.

OPENING STATEMENT OF HON. RICHARD C. SHELBY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ALABAMA

I want to state at the outset that I am appreciative of the chairman of the full Veterans' Affairs Committee, G.V. "Sonny" Montgomery of Mississippi, for permitting me, as a member of his committee, to have this hearing here in Mobile this morning, and also designating me to chair it.

I want to thank the veterans, the veterans' organizations and the entire community of Mobile and south Alabama for the warm welcome you have given us here.

This is a very important hearing and it is being conducted by the Subcommittee on Hospitals and Health Care as an essential element of its legislative and oversight responsibilities.

I want to assure the veterans of the area that those responsibilities have always been vigorously pursued by the Committee on Veterans' Affairs of the House of Representatives in Washington.

I have been a long-time member of the committee. It is viewed as the most bipartisan one in the Congress. It is not viewed as Democrat, Republican or independent, but operates in a manner best for the veterans of America.

This committee's deliberations and actions knows no party lines and I am sure it will continue to serve both veterans and the people of the country.

The purpose of this morning's hearing is to take testimony on the needs of eligible veterans of south Alabama and the Panhandle of Florida for better access to VA health care. There is a small VA outpatient clinic located here in Mobile at the present time. Its resources are most limited. A much larger VA outpatient clinic has been approved for Pensacola, FL. It will be a leased facility and is scheduled to open in August 1986.

For some time now, the VA and its Medical District No. 10 have developed statistical data to support the construction of a new VA Hospital in the Florida Panhandle. As a result, a VA Medical District No. 10 produced a Florida Panhandle workbook in August 1983. It has been widely referred to by some VA officials in the press recently; so, without objection, I am introducing into the record a report by a Committee on Veterans' Affairs consultant who visited Mobile a year ago to take an in-depth look at Providence Hospital and to make recommendations as to its suitability for acquisition and operation as a VA facility.[1] I am also introducing the Panhandle Work Book into the hearing record.[2]

I will say at this point that the recommendation of the VA consultant who came to Mobile at the request of the Veterans' Affairs Committee is most favorable for the acquisition of the Providence Hospital.

To be most candid, the acquisition of this property in Mobile makes good sense to me. Some of the reasons for my statement are:

First, it is the most economical way to go for taxpayers—$69,000 per bed in the existing Providence Hospital as compared to more than $440,000 per bed for new construction.

Second, VA's longstanding policy of locating hospitals adjacent to or as close as possible to approved schools of medicine. The University of South Alabama School of Medicine in Mobile is the only such school on the gulf coast between New Orleans, LA, on the west and Tampa, FL., on the southeast. To my knowledge this longstanding policy would be violated for the first time if a hospital was constructed at Fort Walton Beach.

Third, the largest concentration of veterans in the south Alabama-Florida Panhandle is in the Mobile area. On first brush, it would appear that construction of a new VA hospital in the Florida Panhandle would be to serve retired military personnel rather than the veterans in true need of a health care facility.

Fourth, more than 50 percent of all veterans residing in the central gulf coast would be within 1 hour or less by car to the Providence Hospital site here in Mobile.

Just this morning, at my request, along with some members of the committee, I toured the Providence Hospital. I found it to be everything it has been said to be. I was impressed. Now, having said that, the American veteran, as well as the public at large, expect us to be fair-minded and to hear all sides of matters that come before us. It is for this reason we conduct these hearings. Maybe there is something we are missing. If so, we want to know about it and be in a position to act in the Congress of the United States on behalf of the veterans and the taxpayers.

---

[1] See p. 47.
[2] See p. 51.

Our witness list this morning, as I mentioned earlier, is formidable and I will be pressed to get through it. For this reason, we will take a lot of people as groups and form panels. I would request that all witnesses make their statement as brief as possible and I will submit, without objection, their written comments into the record and leave it open for another week for any additional comments.

First of all, I want to again welcome some of the distinguished governmental leaders who are here this morning.

On my left, I have my colleague, Congressman Wayne Dowdy of Mississippi who has joined us for this hearing. Wayne is a member of the Veterans' Affairs Committee in the U.S. House of Representatives and he is also a member of the Energy and Commerce Committee. We serve together on both.

On my right is Congressman Alan Mollohan from West Virginia. He is also a member of the Veterans' Affairs Committee. This is his first visit to Mobile and I think he is impressed with what he has seen.

I want to welcome both of you to the committee hearing. Congressman Dowdy, do you have any comment?

OPENING STATEMENT OF HON. WAYNE DOWDY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSISSIPPI

Mr. DOWDY. I want to thank the committee and Chairman Montgomery from the State of Mississippi for authorizing and directing that we come to Mobile to take testimony to go back to Washington. As Mr. Shelby has already said, perhaps you can summarize your statements, but please rest assured that your full statements will be read by staff people and by members of the full Veterans' Affairs Committee upon our return to Washington.

I want to thank Mr. Callahan for hosting the group and for being a persuasive advocate for the purchase of Providence Hospital, and my friend, Mr. Mollohan, from the State of West Virginia, who is a very active and able member of the Veterans' Committee. I especially want to thank Richard Shelby from the State of Alabama. Richard is a subcommittee chairman of the Veterans' Affairs Committee. He is also on the Energy and Commerce Committee. I have come to know Richard Shelby as a very capable, intelligent Member representing the people of Alabama.

Very briefly, Mr. Chairman, I have read a lot of the testimony. I know Richard Shelby has been already working on the Providence issue in Washington, DC. You would wonder how somebody in Washington would have heard of the Providence Hospital in Mobile, AL, and that is because Richard Shelby is a very effective legislator on behalf of the people of Alabama.

I am here today to learn. I don't have a firm position on this matter yet. There are some questions in my mind. I cannot argue with the proposition that the purchase of Providence Hospital is at the present time a cost-effective move. It is a good buy. As Mr. Shelby has pointed out, you are buying the hospital for a fraction of new construction costs, but I would hope that some witnesses would move on beyond the present time. We have budgetary constraints in Congress now and those of us on the Veterans' Committee and most Members of Congress think that the No. 1 priority of

the U.S. Government is protecting the interest of the American veteran, the people who have laid their lives on the line. My consideration today, more than just whether or not this is a good buy at this particular time, is more long ranged.

First, how would the purchase and the operation of this particular hospital affect the substantial investment which is being made in the Biloxi hospital, about 70 or 75 miles from here? Would this mean that the taxpayers have spent millions and millions and millions of dollars unwisely on the tremendous program that we have ongoing in Biloxi?

Those of you who are veterans and are very active in your veterans' organizations, I hope you do as I did a couple or 3 months ago and go over to the Biloxi hospital to see the changes that have been brought about in the last few years over there and what is on the drawing board and already committed. The Federal Government has already committed millions and millions of dollars to an elaborate renovation of the Biloxi facility.

Second, I want to know, for my own purposes, what the 10- or 15-year projections have to hold on veterans' population, not only in Biloxi and New Orleans and Mobile, but also the area that we would be charged with looking at over in Tallahassee, FL. What are we looking at in terms of 10, 12, or 15 years from now in terms of the numbers of American veterans who will be living in Panama City, FL, or who may be living in Marianna, FL, or who may be living over on the other side of Destin, FL? My point is this, and this is what I am going to be listening for today, Mr. Chairman, would making a good buy, what is admittedly a good buy now, not look so good 15 or 18 years from now when, because of the tremendous appeal of the State of Florida, the tremendous prospective growth of the panhandle area, when only 10 or 12 years from now someone looked up and said we have two really fine hospitals over at Biloxi and Mobile, both of which are not really accessible to veterans who live at Marianna, or Tallahassee or Panama City, who would still be 2 to 3 hours away from a veterans' care facility.

So again, I thank Mr. Shelby for conducting this hearing. He has been talking about the Providence Hospital before the Veterans' Committee in Washington—and of allowing us an opportunity to come down and hear first hand.

Mr. SHELBY. Congressman Mollohan.

OPENING STATEMENT OF HON. ALAN B. MOLLOHAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WEST VIRGINIA

Mr. MOLLOHAN. Thank you, Mr. Chairman. It is likewise a real pleasure for me to be here this morning with Wayne in Congressman Callahan's district and at the urging of the chairman of the committee, Mr. Shelby. If Wayne thinks that it is surprising that he knows a lot about Providence, then what about a Congressman from West Virginia? I do know a lot about it, and the reason is Dick Shelby has beat this drum quite a bit back in Washington.

So it is a real pleasure to come down and look at the facility, which is very impressive. I serve on the Hospital Subcommittee,

and this is the most impressive facility I have seen, particularly if you take into account the cost of the facility.

I do think the questions that Congressman Dowdy raised are very valid and are ones that this committee should explore. Of particular importance is the question of demand, both present and projected. The capacity of this facility to service that demand, and then, of course, the questions of location and proximity. These are the three key areas that will be explored in this hearing.

I must say that this is the kind of hearing that is in the best tradition of congressional field hearings. We'll examine the community need, and explore ways to reach the best solution, with an eye toward satisfying community needs. It is a real pleasure for me to have been invited by the chairman to participate in the hearing and I look forward to the fine testimony that will be submitted.

Mr. SHELBY. We will get on with the hearing. Our first witness is no stranger to anybody in the room. He is the Representative from the First Congressional District serving his first term in the U.S. House of Representatives, the Honorable Sonny Callahan.

If you have any additional comments, the record will remain open for 1 week. If you will please briefly sum up your testimony.

STATEMENT OF HON. H.L. "SONNY" CALLAHAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ALABAMA

Mr. CALLAHAN. Thank you very much, Mr. Chairman, not only for the opportunity to appear before your distinguished panel today, but for the opportunity to do it in my own home congressional district. Not only will this hearing permit me and the rest of the witnesses to insert into the record pertinent data and facts regarding the location of a new veterans' hospital facility, but it has also provided the opportunity for you and others to visit the Providence Hospital and to recognize firsthand the obvious merits of locating a veterans' facility here.

Testimony will be presented this morning which will give indication of some glaring facts which should weigh heavily on the final decision, testimony which will address all of the criteria pertinent to the location of the veterans' facility. I ask you, Mr. Chairman and members of the panel, to couple the facts that you will hear this morning, the facts of need, the facts of numbers, cost effectiveness, community support, medical school affiliates and access, and you will have the best of all worlds readily available to provide the services to our veterans at a savings of nearly $70 million when compared to new building costs.

We, as Congressmen, know probably more than anyone the absolute mandate to begin reducing the deficit, yet, at the same time, trying to preserve as many services as we can to our needy.

The proposal, as evidence will reflect here today, is exactly the businesslike approach to accomplish both of the aforementioned goals.

I appreciate the opportunity to testify before you today and especially, once again, Mr. Chairman, appreciate your making this testimony available here in the great city of Mobile.

So, welcome to Mobile. If I or my staff or any of the people in this room can be of any service to you today, we stand ready and willing to help you.

Thank you.

Mr. SHELBY. Our next witness is the Honorable Lambert C. Mims, mayor of the city of Mobile.

Mayor Mims, briefly sum up your position as the mayor and the leader of this great city.

STATEMENT OF HON. LAMBERT C. MIMS, MAYOR, CITY OF MOBILE, AL

Mr. MIMS. Thank you, Mr. Chairman, Mr. Dowdy, Mr. Mollohan, and Congressman Callahan. We are delighted to have all of you in Mobile. On behalf of the people let me say welcome again.

Having served in public office for the last 20 years in this community, I feel that I am intimately familiar with some of the needs of this community, and especially am I familiar with the needs of veterans because I have visits from them from time to time and they express those needs.

You are presented here with a unique opportunity to not only help the veterans of this area, but to help the people of Mobile in general.

Our unemployment is 12 percent. Our area needs jobs which a Veterans' Administration hospital would provide. It is our information that if this hospital were to be located here, it could mean as much as 2,000 new nonpolluting-type jobs.

The city of Mobile, as you gentlemen are already aware, is rapidly expanding due to the recent opening of the Tennessee-Tombigbee Waterway. In addition to that, we have the discovery of a huge gas reserve in the lower part of Mobile County.

Contrary to the 1980 U.S. census figures which I am told were used by the district 10 office of the Veterans' Administration in drafting its preliminary report, the true population figures, based on the Corps of Engineers' Tennessee-Tombigbee Waterway population figures show that by the year 1990, the total population in Mobile and the surrounding seven counties will increase to 644,000 people. This is an increase of more than 100,000 persons over present-day figures, and I am sure that many of those people in that increase will be veterans who move into this area or who come in with their families seeking employment.

We feel that if these population expansive figures were included in the preliminary report, that the conclusion of the report would be completely reversed.

Mobile has the University of South Alabama here which could provide staffing to a veterans' hospital as required by your own regulations. Our sister city of Pensacola and our neighbors in the panhandle to the east just do not have the prospects of providing that staffing.

If we allow the Providence Hospital to be lost, I am afraid that all the pain and suffering of our veterans who cannot get to the veterans' hospital presently with any reasonable amount of effort will continue.

With budgetary pressures presently on our Federal Government as well as on our own State and city governments, the prospects of funding for a new construction of a VA hospital elsewhere along the coast are pretty dim.

If Providence slips by, I am afraid that all veterans along the gulf coast will have to suffer without a proper facility through the year 2000.

If Washington is truly serious about reducing deficits, I do not see how in the world that they could let this opportunity be passed up.

One of the criteria for establishment of a veterans' hospital is community support. I have never seen as much of an outpouring of bipartisan community support from all areas of the community including the business leaders, community leaders, medical community, as well as all religions and races. Please be assured that this most important criteria is more than met by our area.

Mobile is committed to this project and as mayor of this great city, and on behalf of my two fellow Commissioners, Mr. Doyle and Mr. Outlaw, we stand 100 percent behind this project and we are ready and willing and, we trust, able to do anything and everything required to get this project on line.

Thank you very much.

Mr. SHELBY. Thank you, Mayor Mims.

Our next witness is Hon. John Smith, mayor, city of Prichard.

Mayor Smith, welcome to the committee meeting.

STATEMENT OF HON. JOHN SMITH, MAYOR, CITY OF PRICHARD, AL

Mr. SMITH. Thank you Congressman, and welcome to the area. I do appreciate this opportunity to speak to you very briefly this morning on what I consider a very critical and important matter. I would like to also say good morning to my own Congressman, Mr. Callahan, and congratulate him on getting off to a very excellent start.

Congressman Shelby, I am here to support my colleagues in Mobile and the people in this city as well as the need in having this facility located in this area.

One, the needs of veterans is always first and foremost in a decision such as this and, second, I think the needs of all of the community. As the mayor of Mobile has pointed out, the unemployment in this area, and certainly, when we begin to talk about unemployment, you have to look at the city of Prichard in terms of what impact a facility like this would have on the number of veterans we have in there and also the unemployment question.

Also, the availability and access of such a facility to veterans. Many of my employees are veterans as well as many of the cities in our area, and, of course, this is a regional focal point, this is a growth area, this is part of the Sunbelt boom. Of course, Mobile and the Mobile region are actively participating in setting some of the new standards for dealing with population needs and population growth and accommodating that. Our university facilities here are great resources in this State and are making a great contribu-

tion to our community and certainly would stand to support the decision for locating a facility here.

And then, of course, just our political strength here—this is the home of one of the great American heroes, Senator Jeremiah Denton, and, of course, Senator Denton, along with our Congressmen here, supports very strongly that, as well as many of the other political leaders here, so we bring together all of these dimensions to say to you that we would like and urge very strongly that you consider this place for the veterans' hospital. I do appreciate very much this opportunity to speak before you this morning and to represent the city of Prichard and our county. Thank you very much.

Mr. SHELBY. Thank you very much.

The next witness before the committee is an old colleague of mine. He is a prominent Mobile attorney now. He is certainly no stranger to the audience here, former Congressman Jack Edwards, who spent 23 years in the U.S. House of Representatives and really distinguished himself.

I want to say this before Jack comes up. Jack was the one who, along with Senator Denton and others, brought this hospital to our attention last year. We even got "Sonny" Montgomery and Jack here to a luncheon one day.

Jack, I want you to know that we are not going to pay any legal fees if you send us a bill. [Laughter.]

STATEMENT OF HON. JACK EDWARDS

Mr. EDWARDS. Well, Mr. Chairman, it is a pleasure to have you and your colleagues, my old colleagues, here in Mobile and to see my very able successor, Sonny Callahan, sitting up there. We greatly appreciate the fact that you have come here to hear these folks.

I look around the room and I see real experts sitting here, experts in the sense of the needs of veterans, experts who deal with veterans day in and day out. I know that you are going to have a number of panels where they will be able to participate and build a record that will clearly show the need for this veterans' hospital here.

So what I would like to do for just a moment, if I may, Mr. Chairman, is talk in terms of that part that I know best and that is how you pay for the hospital needs of veterans.

It is no secret that the President's budget this year made a major effort to cut back on many programs. The Veterans' Administration felt part of that ax, if you will, in the President's budget. The President proposed, as you know, to cut back from about five new hospital or major rehab programs a year to two, and I think what that says to me is that we have got to make the veteran dollar go further, we have got to make the veteran dollar be put to better use and that puts a burden on your committee, that puts a burden on the appropriations process and on the President—the White House itself. And so, as I look at that cutback, and I do not suggest that Congress will buy all of those cuts, but we know we have got to do something about the deficit. As I look at that, it seems to me that your committee and the Veterans' Administration desperately need to look for new ways to finance those facilities that our veterans in this country need.

It seems to me that we have an opportunity here in Mobile that is extremely unique. This hospital can be acquired for something in the midtwenty millions of dollars, about a quarter of what you could acquire a new hospital for. It is right in the heart of the large veteran population. It seems to me that it generally fits the criteria that David Stockman in the Office of Management and Budget has set out to try to find innovative ways to provide for the needs of the veterans without having to seek tremendous increases every year in the budget.

I don't know any better opportunity that we could have in this country than to use this hospital as a pilot program to show some innovation.

I know that our friends to the west in Mississippi get a little nervous, and I see my good friend Wayne Dowdy sitting up there, they get a little nervous that somehow we are going to infringe upon Biloxi, Gulfport, and those hospitals over there. I know that there is a major rehab program either getting ready to start or underway over there. I am not sure exactly the status of it, and I know that those facilities need to be rehabilitated and, yet, the program for rehabilitating those hospitals on the Mississippi coast in fact cost more by a substantial amount than it would cost to acquire this hospital.

I think that if you acquired this hospital, sure, it would discombobulate a few beds here and there, perhaps a few on the Mississippi coast, perhaps a few in Montgomery or Tuscaloosa or somewhere, but the overall good that could be done for the veterans far outweighs the little shift here and there. It would not make any major change or substantial change in the Mississippi coastal hospital area.

The situation over in Florida, perhaps you are going to have some people testify from Florida, local pride, I suppose would dictate that they would want a hospital over there. Mobile is the center of the veteran population. This is the center of the area that needs it. In conjunction with the South Alabama Medical School, we can give the tertiary service that is so important to the veterans and, in fact, it would enhance the ability of the Mississippi coast hospitals to serve the veterans by having this tertiary service here as well as over in New Orleans.

The medical hospital, the medical facility, the medical university is what I am trying to say is extremely important nowadays to the location of veterans' hospitals. I hope when you go back, and you write your report and you make your recommendations, that you consider the real assets that go with this proposal. I think that the Veterans' Administration would be well served by acquiring this facility and I know the veterans of this area would be extremely well served.

I thank you for coming down here today.

Mr. SHELBY. Jack, I thank you. I want to tell all of you that we miss Congressman Edwards. I served my first three terms in Congress with him in Washington. He says that he taught me all I know but not all that he knows. So, today I am trying to learn a little bit more from him. I know you are enjoying your law practice and we really appreciate your appearing before us here in Mobile today. As I said previously Jack, you got this thing rolling up in

Washington last year, and I know you are going to continue to work in behalf of this hospital purchase.

Mr. EDWARDS. Let me just say in conclusion, I promised I would not use his name, but I had a root canal this morning and I told my dentist if I were able to come here and testify that I would get up and shout his name to the rafters. At any rate, I am glad I could be here.

Mr. SHELBY. Thank you, Jack.

I have just been handed a letter that was telecopied from Washington this morning from Senator Howell Heflin addressed to me. He wants me to mention his interest in this hearing and his work on behalf of bringing forth this hospital purchase—making it a reality. I am going to introduce his letter into the record, with objection. Senator Heflin is going on record, not only this morning, but on other occasions in favor of this hospital.

[The letter from Senator Heflin appears on p. 122.]

Mr. SHELBY. Senator Denton is not here this morning. He is tied up on other things. However, I want to say in his home town, that he has been working hard, as you know, to try to bring this hospital purchase about. I am trying to do that also.

Our next witness will be Mr. Donald Thompson, Director, Southeastern Region, Department of Medicine and Surgery, Veterans' Administration.

Mr. Thompson.

Mr. Thompson, your written testimony will be submitted for the record in its totality, without objection. If you would just sum up your thoughts on this, it would be appreciated.

STATEMENT OF DONALD THOMPSON, DIRECTOR, SOUTHEASTERN REGION, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION

Mr. THOMPSON. I am honored to represent the Veterans' Administration here today in connection with the consideration of a VA medical center here in south Alabama and the western panhandle area of Florida.

First, I would like to recognize the efforts of a number of the people in the Mobile area who have responded to the VA's challenge in meeting the health care needs of our veteran population in this area.

I would like to begin my testimony with referring to two previous reports prepared by the VA at congressional request. On December 23, 1981, a congressional directive accompanying Public Law 97-101 mandated a 30-year study of the needs of veterans in Florida.

This study was directed due to the rapid growth in the veteran population in the Florida area over the past two decades and the extended growth projected through the year 2010. The study was limited to projecting estimates of hospital, domiciliary and nursing home beds, and outpatient care needs. Included in the geographical considerations were all of the Medical District 12, including the majority of Florida and 19 counties in Georgia, the 8 Florida Panhandle counties of Medical District 10.

As an outgrowth of this study and the pursuit of the medical district initiated planning process, the MEDIPP process which I am sure you are all acquainted with, a second report was published in June 1983 which was the Florida Panhandle Study.

The final report of the 30-year study based the projected hospital bed needs on the VA/GAO bed sizing model which assumes that the historical rates of hospital use will continue in the future. Input was received for these studies from Medical District 12 in Florida, Medical District 10, the VA medical centers planning committees, veterans review groups for medical district planning, the district professional councils, the district administrative councils, and the district executive councils.

It was determined that the supply of inpatient and outpatient services to be provided should be at least comparable to those national levels of availability.

The study conservatively projected the need for an additional 1,525 beds in Florida. Now, these projections were made on the current population and projected population in relationship to certain indices. We based them upon the 1995 total veteran population in a theoretical primary service area around each of the facilities to be considered, the 1995 veteran population over 50 miles from an existing VA facility but within 50 miles of a potential site. The 1995 veteran population over 75 miles rather, from an existing VA hospital but within 75 miles of a potential site. Distance from the population center of the potential site to the nearest existing VA hospital, and the PSA access index which combines distance and population factors to measure the overall potential improvement in access.

The primary consideration was that new hospitals should be located at sites more than 75 miles from existing facilities which would minimize the negative impact upon the utilization of those existing hospitals. This exhaustive study required 2 years to complete and it identified four final potential sites, including Palm Beach County, which is now in the budget process; Brevard County which is planned for this coming year, one in the Florida Panhandle counties, about 215 beds and that was only after looking at the utilization of available Department of Defense beds in lieu of new construction, and, Lee County, FL.

The planners agreed that these facilities be nonteaching hospitals and provide predominantly primary and secondary care.

The MEDIPP process has been in effect since 1981. It is through this process that the VA identifies present services, projected needs, and recommended additions, deletions, or changes in service.

A planning board consisting of professional and administrative persons representing all VAMC's within a district is charged with identifying areas of change. After careful study, the recommendations of the planning board are reviewed by community advisory groups, service organization representatives, and finally by the district executive council comprised of all the Directors within the district.

The recommendations of the district executive council are forwarded to the VA Central Office for a series of reviews by the Regional Directors, the Associate Deputy Chief Medical Director, all the professional services, the Chief Medical Director——

Mr. SHELBY. Excuse me, Mr. Thompson. You are going to run over your 5 minutes. Your written testimony will be submitted to the record. Please sum up so that we may have time to ask you questions.

Mr. THOMPSON. That will be fine.

With the proposal of the Providence Hospital in Mobile, the Administrator asked us to revisit the issue of need for a hospital in this area and that process is in place at this particular time.

Medical District 10 has been reviewed including the Mobile area. We have relooked at our demographic data. We are projecting a veteran population of approximately 55,000 that will be served in the theoretical primary service area of Mobile. A substantial proportion of these 55,000 projected veterans are included in the present 90,000 to 100,000 veterans currently being served by the Medical Center in Biloxi, MS, located approximately 64 miles west.

The entire package, after receiving all of the data and coming back to the Mobile area for an on-site review on February 28, 1985, has been sent to the central office. The recommendation that has been made at this point in time is that the information contained did not support the need for a hospital in Mobile.

[The statement of Mr. Thompson appears on p. 124.]

Mr. SHELBY. We would like to address a few questions to you.

We know the views of the VA Medical District 10 to construct a new VA hospital in the Florida Panhandle, with the preferred location being in the Fort Walton Beach area.

Please give the subcommittee a specific date to begin construction of such a hospital and when it would be scheduled to treat veteran patients?

Mr. THOMPSON. Mr. Chairman, I could not give you a specific date, because that is yet to be determined. As you are probably aware, the first two priority projects shown in the Florida study are currently in the budget consideration. Palm Beach County is in the budget and the Brevard County facility was a budget year 1986 projection and it is involved in consideration at this time.

Mr. SHELBY. When you say it is in the budget, it is also going to have to be not only appropriated, it is going to have to be authorized, isn't it?

Mr. THOMPSON. Absolutely.

Mr. SHELBY. And when you say that the Veterans' Administration makes a recommendation, that is just a recommendation?

Mr. THOMPSON. Absolutely.

Mr. SHELBY. And it has nothing to do with the legislative process that we in the Congress have to first authorize the construction, the amount, and so forth. The Appropriations Committee will then have to appropriate the money.

Mr. THOMPSON. Absolutely.

Mr. SHELBY. OK.

Mr. THOMPSON. But, Congressman, the important thing to remember in our studies today was that our effort was to determine the need for a facility in this area first and then look at the construction question.

Mr. SHELBY. This could be 10 or 12 years down the road, if ever, couldn't it, as far as Florida is concerned?

Mr. THOMPSON. Yes, sir, it could, and it may be likely under your budget realities but I can't deal with that because I can't project it.

You must remember that in developing the data for the Mobile area, we used three counties: Mobile, Baldwin, and Washington. We used these because the existing facility at Biloxi currently serves the people of Mobile. We arbitrarily utilized the State line of Mississippi as the cutoff point to the West. Looking at the veteran population and the projected population within that area, we see that by the year 2000 there will be a 5-percent reduction in veterans population in that area: that is, Mobile, Baldwin, and Washington counties.

Mr. SHELBY. Let me interrupt you for 1 minute, if I can. Why didn't you use Baldwin County?

Mr. THOMPSON. We did use Baldwin.

Mr. SHELBY. And what other counties?

Mr. THOMPSON. Baldwin, Washington, and Mobile.

Mr. SHELBY. And why not some other counties north and east?

Mr. THOMPSON. Because of the 75-mile radius criteria that we are using in all instances.

Mr. SHELBY. OK. Given the large Federal deficits that former Congressman Edwards alluded to earlier, and that we in the Congress now face, doesn't it make sense to acquire an existing first-class hospital for, say $24 million, or whatever it is, as opposed to new construction somewhere in the Florida Panhandle which may never come about? In other words, isn't a bird in the hand worth something to the veterans who are getting older every day? [Applause.]

Mr. THOMPSON. If you will permit me to express an opinion, and that is all this will be.

Mr. SHELBY. I think they have expressed it for us. Go ahead. [Applause.]

Mr. THOMPSON. In projecting population, there are only three things one can look at: births, deaths, and migration. It has been inferred that we have used statistics that perhaps are faulty. However, we used the University of Alabama Center for Business and Economic Research Data. That is the office that officially projects the migration to the State of Alabama. They project that there will be a growth of general population However, the veterans' population because it does not include births in its population projections, and should not, is projected at a 5-percent reduction while there is an increase of 18 percent in projected veterans' population during the same time period, in the Florida Panhandle.

Mr. SHELBY. Mr. Thompson, is there a medical school at Fort Walton Beach, FL?

Mr. THOMPSON. No; there is not.

Mr. SHELBY. Why would you in your recommendation ignore the VA criteria regarding that when you have it here in Mobile.

Mr. THOMPSON. To my knowledge, Mr. Chairman, there is no criteria that requires the colocation of a Veterans' Administration hospital.

If I may continue with that of the four hospitals currently in planning based upon Florida projections, the Florida report, none of them were to be affiliated, all were to provide secondary and primary care with tertiary care referral to the next nearest facility.

There are several reasons for this. We recognize the great importance of colocation. We have since 1946 placed the majority of our facilities near medical schools. However, it is not a requirement.

Mr. SHELBY. OK, let me ask you another question. You mentioned the VA Hospital at Biloxi.

Mr. THOMPSON. Yes.

Mr. SHELBY. Have you done any study about what impact, if any, there would be on the Biloxi facility if this Mobile hospital was purchased and set up?

Mr. THOMPSON. Yes, sir, we have. The study of the impact on Biloxi, of course, is part of the MEDIPP process and we would do that regardless of where we planned it. Essentially what it boils down to is this. The Biloxi hospital has approximately a 150,000 veteran population that it services. You could break that population roughly into thirds. One-third of it resides in southern Mississippi, one-third in the Mobile area, and the remaining one-third in the western panhandle area, particularly Escambia County and New Orleans.

Essentially what the establishment of a facility in Mobile would do would take away approximately two-thirds of the workload of that facility. I should say that all of the construction that has gone on in Biloxi has been predicated on previously existing plans, that included the population from these areas and therefore the size of the projects, the staffing of the hospital, the medical programs that are in place at the hospital are all predicated on continuing to serve these areas.

Unfortunately, all but the Nursing Home Care Unit has already been committed and construction is well on its way to completion. In fact, several phases have already been completed.

Mr. SHELBY. Have you made yourself familiar with Mr. Ralph Casteel's investigation of the Mobile facility here?

Mr. THOMPSON. Yes; I certainly have.

Mr. SHELBY. OK; are you familiar with some of the statements that he feels that the purchase of the Mobile hospital will have little impact, if any, on the West—in other words, the Mississippi area, as opposed to the Florida area?

Mr. THOMPSON. I didn't read it that way, but perhaps one could. I would like to point out, however, that one of the very first sentences in the conclusion was that if the Veterans' Administration determined a need for a facility in this area, then the Providence Hospital would be an extremely wise selection to consider.

Mr. SHELBY. The Veterans' Administration would make a recommendation. The Congress, however, would really determine the need, wouldn't it?

Mr. THOMPSON. Yes, sir.

Mr. SHELBY. Isn't that the scheme of things in the legislative process?

Mr. THOMPSON. That is right, sir.

Mr. SHELBY. Mr. Mollohan?

Mr. MOLLOHAN. Thank you, Mr. Chairman.

It occurs to me that you are carrying a very large burden here this morning and I would be interested in exploring some of the assumptions that you have set forth. First of all, with regard to population, you suggested that there was some evidence that has

been brought forth at the time you were doing your study or subsequent to it, which would bring into question your finding——

Mr. THOMPSON. It would——

Mr. MOLLOHAN. I am not finished. It was represented earlier by witnesses that the Tombigbee study might bring into question your findings. In addition to the Tombigbee study, is there any other evidence that has been forthcoming that questions your population growth projections?

Mr. THOMPSON. No, sir; the question on the Tombigbee study is simply that the Corps of Engineers in making their projections, and it is stated so in their report, based upon their conclusions on a migration of or a redistribution of population along the waterway. It makes a point that it is not new population. It is simply a redistribution of population living along the waterway.

Mr. MOLLOHAN. Would it be a redistribution of population into this immediate area?

Mr. THOMPSON. But what I want to point out——

Mr. MOLLOHAN. Would you answer that question?

Mr. THOMPSON. Yes.

Mr. MOLLOHAN. It would be a redistribution of population into the Mobile area?

Mr. THOMPSON. Right, but from the same area that is already considered in the population projection.

Mr. MOLLOHAN. I see, it would just bring more people closer, though it wouldn't necessarily add more people to the overall geographic area that you have considered?

Mr. THOMPSON. Right.

Mr. MOLLOHAN. That is your estimate?

Mr. THOMPSON. Yes.

Mr. MOLLOHAN. It is almost inconceivable to me that you would have a declining veterans' population that would be serviced by the hospital. I know in my area that while the total veterans' population may decline, that population is going to require more hospital health care services. When you say there is going to be a 5-percent decrease in this area, does that figure refer to total veterans' population, or that population that is going to be increasingly using a hospital health care facility?

Mr. THOMPSON. It is the total population and that is the reason we would——

Mr. SHELBY. It is the total population?

Mr. THOMPSON. That is right, and that is the reason we have the nursing home programs already planned at Biloxi.

Mr. MOLLOHAN. I understand, but that does not suggest there will be a decline in the veterans' population that will need increasing health care services.

Mr. THOMPSON. We concede the workload will probably be maintained at an increasing level with the assumption that as you get older your needs for care increase.

Mr. MOLLOHAN. Right, and we do have an aging veterans' population?

Mr. THOMPSON. That is correct.

Mr. MOLLOHAN. And you would have an aging veterans' population in the Mobile area?

Mr. THOMPSON. You would have the same aging veterans' population in all areas.

Mr. MOLLOHAN. So it would be reasonable to assume that the demand for hospital health care services would increase although you might have an overall decrease in veterans' population?

Mr. THOMPSON. Yes; at the same theoretical rate that it would rise in all localities nationwide.

Mr. MOLLOHAN. I would like to quickly look at service capacity. You indicated that there was a considerable growing need in the northern Florida Panhandle area; is that correct?

Mr. THOMPSON. Yes, sir.

Mr. MOLLOHAN. And that there are several different ways of servicing that need?

Mr. THOMPSON. That is right, sir.

Mr. MOLLOHAN. A hospital would be one of them, a new veterans' hospital would be one of them?

Mr. THOMPSON. Outpatient clinic.

Mr. MOLLOHAN. And sharing services with the Department of Defense would be another?

Mr. THOMPSON. That is right, sir.

Mr. MOLLOHAN. Did you give serious consideration to that alternative?

Mr. THOMPSON. That is right. We have looked at Tyndall Air Force Base, Eglin, and the naval hospital in Pensacola.

I think I should point out also that it has been stated here today that our only goal would be to construct a hospital in the panhandle, and that the cost figures are astronomical in the panhandle or anywhere else in construction as opposed to purchase.

Any time we would consider placement of a hospital, we would look for as many alternatives as we could.

Mr. MOLLOHAN. I understand. Yes; you just stick with my line of questioning.

Mr. THOMPSON. OK, the Naval Hospital at the present time in Pensacola has something like 40 unoccupied beds. Visits have been made with the commanding officer there and he is of the impression that they could not provide service.

Mr. MOLLOHAN. Well, let me ask you this before you get into specifics: How seriously did you consider that alternative, of sharing DOD facilities?

Mr. THOMPSON. Quite frankly, we haven't considered the question of constructing a hospital yet.

Mr. MOLLOHAN. That wasn't my question, though. How seriously did you study the DOD option?

Mr. THOMPSON. Serious enough to visit with the military people.

Mr. MOLLOHAN. Well, it constitutes 2 pages in your overall report here. Although it is certainly not any extensive study, it does reflect that there is considerable excess capacity at Pensacola and Eglin, and Tyndall, is that——

Mr. THOMPSON. There is excess capacity.

Mr. MOLLOHAN. There is excess capacity in those hospitals?

Mr. THOMPSON. That is right, and in the projection for a new facility for the VA, it is limited to 215 beds.

Mr. MOLLOHAN. OK. Well, if you have excess capacity over there that can share and we are in a very tough budgetary crisis, wouldn't it seem reasonable to opt for the sharing alternative?

Mr. THOMPSON. To the extent it would meet the veterans' needs; yes, sir.

Mr. MOLLOHAN. Well, they are hospitals, aren't they?

Mr. THOMPSON. Certainly.

Mr. MOLLOHAN. Well, are they adequate for active duty personnel?

Mr. THOMPSON. I would assume so, although they are not operating at this time, I would say they are; yes, sir.

Mr. MOLLOHAN. That brings me to the final question: When you look at relative costs, particularly in light of the fact that you have excess bed capacity in the northern Panhandle of Florida, can you think of a better deal overall than the Providence Hospital? Have you ever seen a better deal or opportunity? That is a "yes or no" and then you can explain.

Mr. THOMPSON. OK. No, provided——

Mr. MOLLOHAN. So this is the best deal you have ever seen and then go ahead and clarify.

Mr. THOMPSON. It is the best deal on the surface I have ever seen. However, it is no bargain at all if there is no need.

Second——

Mr. MOLLOHAN. And that is a given, obviously.

Mr. THOMPSON. Yes; well, I would like to finish my train of thought.

Mr. MOLLOHAN. Well, we will listen.

Mr. THOMPSON. What I would like to say is, the figure of $24 million, if that is the final figure, and $69,000 a bed compared to $440,000 that I heard this morning, which, I am not familiar with, relate to the difference in a construction project and a purchase project in that the construction project is a turnkey operation. It means that that facility is constructed. It meets all the life safety codes. It meets all current codes applicable to Government buying, it means there is no asbestos in the building.

Mr. MOLLOHAN. Sure; no one would ask you to buy Providence if it didn't meet all of that. I will tell you, from what I saw, it certainly did. My time is running out and I am sure you will be given a chance to summarize. I will just end the way I began. You have been given a very tough assignment here, particularly in light of the excess capacity in the northern Panhandle of Florida, and the tremendous buy here.

Mr. SHELBY. Before we get into our next panel of witnesses, I want to make a comment to Mr. Thompson.

Obviously, you didn't consider a lot of things in this report. It looks to me like it is flawed at the outset. If you didn't consider excess beds at Eglin as large as that facility is, at Pensacola and Tyndall, this report isn't worth 10 cents. [Applause.]

I next recognize the gentleman from Mississippi, Congressman Dowdy.

Mr. DOWDY. Mr. Thompson, I appreciate your sharing the benefit of your expertise with us today.

The study, you alluded to a June 1983 study, I think, and based on that study, it is my understanding you are going forward with the construction of a hospital at Palm Beach, FL, is that right?

Mr. THOMPSON. That is right.

Mr. DOWDY. How far along are we on that?

Mr. THOMPSON. Oh, we are just in the earlier stages of identifying potential sites?

Mr. DOWDY. And then Brevard County?

Mr. THOMPSON. Brevard County was a suggestion by the Veterans' Administration; yes, it was recommended by the Administrator. It is not in the cycle at this point.

Mr. DOWDY. And you also, if I recall correctly, stated that this study not only included the State of Florida, but it included some counties up in the State of Georgia?

Mr. THOMPSON. Nineteen counties in Georgia.

Mr. DOWDY. Is it the long-range planning of the Veterans' Administration that should a facility be constructed somewhere in the Florida Panhandle, then I take it that facility would be charged with the responsibility for some portion of the State of Georgia?

Mr. THOMPSON. Yes, that is the way it is now.

Mr. DOWDY. I see.

Mr. THOMPSON. If we were to build a hospital anywhere in the panhandle, the furthest from a VA facility that the people in this area would travel would be 60 miles. The closer we could build the Florida facility to the epicenter—a hospital or purchase a hospital toward the epicenter of the panhandle, the closer we would bring the service to a larger number of veterans.

Mr. DOWDY. Let me ask you some questions. I have reviewed the statement of my colleague, Mr. Earl Hutto, from Florida, who also has some interest in this matter and he was unable to be with us today, but he makes reference that northwest Florida is the only area in Medical District 10 which will sustain growth in veterans' population projected over the next decade. Does that correspond with the findings of your study?

Mr. THOMPSON. It does.

Mr. DOWDY. When you defined the primary service area, Mr. Thompson, and I think you admitted in response to questions of Mr. Shelby, you have admitted that the Providence Hospital is a lot of hospital for a little money at this time, but let me ask you, in terms of the service area for a facility in Mobile, what portion of the veterans' population in the Florida Panhandle would meet the theoretical service area criteria the Veterans' Administration has established?

Mr. THOMPSON. It would be essentially Escambia County, which is the furthest west county in the Pensacola area.

Mr. DOWDY. And you—it is the Administrator—your position then that Panama City, Destin, the Fort Walton Beach area, and Marianna, FL, and even those 19 counties up in southwest Georgia that you talked about, they would not be within the theoretical service area of a hospital should one be located in Mobile?

Mr. THOMPSON. That is correct. Tallahassee you could include in that also. It is a matter of distance. No matter where you locate a facility, if we were to locate it in the panhandle, care would always be available within 64 miles from Mobile. Locating a facility here

would place a facility more than 64 miles from three times the Mobile area population in the Florida Panhandle.

Mr. DOWDY. Let's go on. How much money has the Federal Government—how far along are we on the renovation procedure and rehab procedure of the Biloxi facility?

Mr. THOMPSON. I do not have exactly what the current percentage of completion is. We have completed renovation of several buildings. We have built the new boiler plants and the consolidated laundry that were required. We have closed a portion of the Gulfport hospital for reconstruction of ward buildings there. The only remaining uncommitted portion of that total construction program of somewhere in the neighborhood of $80 million is $5 million for the nursing home that is scheduled for 1988.

Mr. DOWDY. Now in your best estimate, Mr. Thompson, given the completion of those moneys which have been committed with the facility in Biloxi, assuming the purchase and the operation of the Mobile proposal by the Federal Government, the Veterans' Administration, you have testified that the primary service area for the Biloxi hospital is, I believe you testified up to 100,000 veterans?

Mr. THOMPSON. It is actually close to 150,000.

Mr. DOWDY. 150,000.

Mr. THOMPSON. With approximately one-third in each of the three areas I described.

Mr. DOWDY. And I know that the moneys which have been expended in the rehabilitation of the Biloxi facility were authorized and appropriated based on those veterans' numbers of 150,000 people.

Mr. THOMPSON. That is correct.

Mr. DOWDY. All right. If we were to locate a veterans' hospital 64 miles from Biloxi at Mobile, in your best estimate, Mr. Thompson, what would the theoretical service area impact for the Biloxi facility, which is now estimated at 150,000 veterans? How adversely impacted would the mission of that Biloxi hospital be?

Mr. THOMPSON. The population base is a million PSA at Biloxi would fall to 47,000, approximately two-thirds of the total workload.

Mr. DOWDY. So the ideal solution to our problem—I have read Mr. Hutto's testimony, and I know Mr. Shelby, Mr. Callahan, Mr. Denton, Senator Denton, Senator Heflin, and others, their position, the ideal solution to our problem would be if only the Providence Hospital were at Fort Walton Beach; is that right?

Mr. THOMPSON. That would be ideal.

Mr. DOWDY. I want to thank you, Mr. Thompson, for your very helpful testimony this morning.

Mr. THOMPSON. Thank you, sir.

Mr. SHELBY. I want to now recognize the gentleman from Alabama, Congressman Sonny Callahan.

Mr. CALLAHAN. I don't have any comments for Mr. Thompson, Mr. Chairman, except to say that I think that Mr. Dowdy's comment summed it all up. The very fact your report services only need but there are some areas I question as to the validity of that report. It is sort of like an unbiased report of the Civil War from a northern point of view.

I do see that you spent 2 years of exhaustive study, and evidently if that entire 2 years was spent on the needs of Panama City, or Florida, but nevertheless, with all due respect to the work that you have put into it, I think that we, as Government leaders, must recognize the fact that we have got to start saving some money. And the fact that your report, which probably it was not intended to do so, the fact that your report is based upon your projected needs and does not take into consideration the cost effectiveness factor, a medical school is established here already, to me leaves a lot to be desired, but I do appreciate your coming.

Mr. SHELBY. Our next panel will be Dr. Frederick P. Whiddon, president, University of South Alabama; Dr. Stanley E. Crawford, dean and vice president for medical affairs, University of South Alabama; Mr. Clyde Cox, assistant dean, School of Medicine, University of Alabama at Birmingham.

Gentlemen, please come up. We hope not to take all of the time we have taken thus far with you. We know that you are eminently qualified to speak on the subject you are about to take on.

Your written testimony as we have said earlier will be submitted for the hearing record in its totality without objection. Please briefly sum up your remarks.

It is our understanding that Governor Wallace is on his way here to speak this morning. I told the Governor that if he could get down here, that I would here his statement immediately upon his arrival. Therefore, when he does arrive, gentlemen, I will take him directly. Since he is the Governor, is that OK with you?

Dr. WHIDDON. Mr. Chairman, I will endeavor not to get in the way of Governor Wallace if I can possibly avoid it.

Mr. SHELBY. Dr. Whiddon, do you want to lead off?

STATEMENTS OF A PANEL CONSISTING OF DR. FREDERICK P. WHIDDON, PRESIDENT, UNIVERSITY OF SOUTH ALABAMA; DR. STANLEY E. CRAWFORD, DEAN AND VICE PRESIDENT FOR MEDICAL AFFAIRS, UNIVERSITY OF SOUTH ALABAMA; CLYDE COX, ASSISTANT DEAN, SCHOOL OF MEDICINE, UNIVERSITY OF ALABAMA AT BIRMINGHAM, APPEARING ON BEHALF OF JIM PITTMAN, DEAN, SCHOOL OF MEDICINE, UNIVERSITY OF ALABAMA AT BIRMINGHAM

STATEMENT OF DR. FREDERICK P. WHIDDON

Dr. WHIDDON. Thank you, Mr. Chairman, and members of the committee for this opportunity. The savings for the fiscal facilities has been well and adroitly made, so I will confine my statements to the environment and the areas which will, in my opinion, nurture the very finest health care for the veterans themselves.

Dr. Crawford will speak specifically to the contributions of the medical school. He is on my left. He is vice president and dean of the medical school.

Now, in the first place, the overall environment, I would like to respectfully challenge some of the statements made with regard to demograpics, the shifts in populations. I would readily admit that the panhandle is going to experience more growth in the next decade, the next two decades than we are. However, our growth is

projected at a very substantial growth, even though it is not quite as great as that.

We have, even though I don't have the statistics at the moment, I hope to have them in a few moments, I think that we can prove that the veterans' population will increase rather than decrease in this metropolitan area and in a 75-mile radius.

It seems to me that one of the most frustrating experiences in one's life is to have qualified for all of the criteria to get something and then have the rules changed, Mr. Chairman.

Now, let me be specific. There is, as a matter of fact, a veterans' hospital in Gainesville adjacent to the medical school

The next medical school in Florida was opened at University of South Florida in Tampa. They started their medical school the year before we did, but much more modestly than we did and committed much less to it, but they couldn't even get the first class in before the Veterans' Administration was there with the bricks and mortar to build a Veterans' Hospital on that campus, and this was true all over the United States of America. But here we have a medical school 64 miles away from an excellent veterans' hospital to the west. We have a million people—it is an incontrovertable fact that we have a million people in a 60-mile radius of the University of South Alabama and I would also like to challenge that we would not diminish or take away one bit of the service or need for the facility in Biloxi and it is not gratuitous because we have a distinguished Mississippian on the panel this morning.

Now, I feel you can graphically make the points about brick and mortar, about fiscal facilities, and the fact that you can get an excellent facility for 25 percent of what it would cost, you can get it now, you can get the service now. Also, consider this, once the facility is built at XYZ location or is built here, what is it going to cost the Veterans' Administration to operate the facility and at what level will the facility be?

What sense does it make to build a first level or a second level care facility in another location when you have ample facilities on a county or a city basis, when you can have a tertiary facility in Mobile?

The final point, we are all well aware of the staffing, the large numbers of staffing which Dr. Crawford will cover, but consider also the Allied Health, the College of Allied Health, all of the professionals that are available there. Consider the enormous cost of a first-class medical library which we provide and staff and which would be readily available, not only to physicians but to all the people who staff this hospital. Consider the total environment and then ask yourselves the question, what about the capacity to deliver health care? The level of health care? The quality of it and the capacity to do it? These questions are important as well as the costs. I would be pleased to try to respond to any questions.

Mr. SHELBY. We will go on with the panel. Thank you Dr. Whiddon for your concise statement. I have thought from the beginning that we should not ignore the criteria of locating VA hospitals near medical schools for research purposes. Dr. Stanley Crawford, dean and vice president for medical affairs, University of South Alabama.

Dr. CRAWFORD. Thank you.

Mr. SHELBY. Excuse me, Doctor. I have just been informed that Governor Wallace is here. I think we all should commend him for coming to Mobile for this hearing. If we can take the Governor now, Dean, and then come back. Governor Wallace, if you will come on up? [Applause.]

Governor, we welcome you to this hearing in Mobile. Some of the Congressmen here with me have never met you, and they only came down because they wanted to meet you.

On my right is Congressman Alan Mollohan. He is a Democrat from West Virginia, and a member of the Veterans' Affairs Committee. He remembers when you campaigned in his State very successfully.

On my left is Congressman Wayne Dowdy, from Mississippi, our neighboring State. Of course, you know Congressman Callahan, our colleague from Alabama.

Governor, we do appreciate your coming to this hearing regarding the possible acquisition of the Providence Hospital for a veterans' hospital here in Mobile. Your written testimony, Governor, will be submitted for the record in its entirety. If you want to comment orally on this, you may proceed. We welcome you.

STATEMENT OF HON. GEORGE C. WALLACE, GOVERNOR OF ALABAMA

Governor WALLACE. Well, thank you very much Congressman Shelby and other distinguished members of the committee. We are happy to have you in Alabama, you who are from out of the State.

I know that prior to my testifying that a number of people have already spoken to you and have outlined the reasons why we hope that the committee will decide that the purchase of the Providence Hospital will be a savings, not only to the country, but also to the great number of veterans in the area of Alabama and the panhandle, and even Mississippi.

I have a brief statement I am going to make and I am going to be brief because I have been before a committee hearing before. I know that you do not want a long testimony from any one of us, but we are glad to have you in Alabama. You, with the committee, along with our Richard Shelby and, of course, Sonny Callahan.

Not only do the veterans of our great State welcome you, but we all appreciate your coming here to conduct this most important hearing. I come before this committee, both as Governor and a World War II combat veteran.

Today, the beautiful port city, Mobile, is presented with a unqiue opportunity to provide quality and economical health care to the deserving vetrans of South Alabama as well as the Panhandle of Florida.

The need for a Veterans' Administration hospital in our area has been with us for many, many years. The veterans of this region have suffered, and continue to suffer, because of the lack of highly specialized and comprehensive medical care available to them.

When Providence Hospital became available to the Veterans' Administration, approximately a year ago, a once-in-a-lifetime opportunity presented itself whereby the VA could purchase an existing

hospital in excellent condition—I am getting old, I can't turn the pages like I used to——

Mr. SHELBY. We have that trouble ourselves.

Governor WALLACE [continuing]. At a minimum cost.

Mr. Chairman, the cost is 25 cents on the dollar based on 1985 new construction dollars. In addition to providing for 349 acute care hospital beds, Providence would also provide a 126-bed nursing home unit.

According to a recent Veterans' Administration hospital study, entitled "Caring for the Elderly Veteran," the nursing home unit alone would cost $6.5 million to construct and if the Providence proposal is accepted, it will be given to the Veterans' Administration within the $24 million purchase price. Alabama needs you, and most importantly, her veterans need you. The time to act is now. South Alabama's economy and population is rapidly expanding. With the Tennessee-Tombigbee Waterway recently opening, and large reserves of natural gas having been discovered off Alabama's shores, our aging veteran population into the year 2000 will more than double.

Mr. Chairman, if this fiscally responsible opportunity to assist our veterans is lost, I am afraid that it will never be presented again.

In my opinion, this conversion endeavor will be applauded by all Americans while serving as a pilot project for the Veterans' Administration and other governmental agencies regarding future creation of medical care facilities.

Mr. Chairman, America owes a great debt of gratitude to our veterans who have honorably and faithfully served in the Armed Forces during our country's time of need.

Alabama, in particular, has always led the way in America's volunteer forces during periods of war. Now is the time to recognize the tremendous needs of the veterans in this area by supporting this worthy endeavor to convert Providence Hospital into a VA Medical Center.

Of course, my office stands ready to assist you and your committee in any way that we can. I do know from experience that we are having so many people reach the age of 65 and older, or above 60, who were in World War II.

I never realized when I went to my first VFW meeting and coming back from combat service over in Japan on a B–29 bomber crew, we were all kids, you might say, and now we are all getting to the time of retirement.

And as one that didn't get disabled in this fight, in an armed conflict, my political career gave me more flack than I got during War War II; however, I realize as those like me, and many of them are veterans, there are many that are going to need hospitalization and need constant care, that there is a lot of suffering, because I suffer myself. I am the Governor of the State and, therefore, I am doing all right and being looked after, but I do know thousands of people in this State, that we have started the so-called Homebound Program for, and these young people who got in this condition or worse, the quadraplegics, as you have many of those in the service as a result of wounds in battle, in their spinal column, that is only one of course, and I do know that those people in Alabama, we pro-

vide the program for them called the Homebound Program, so we are facing soon, and right this moment, and in the next 5 years especially, the need for so many of these people who suffer.

I suffer myself, even in spite of the fact that I am the Governor of Alabama, I have all of the opportunity to be looked after. But there are those out there who are veterans who are suffering to the extent, in this area of Alabama, Mississippi, and Florida, and this great growing area of our State as a result of the Tennessee-Tombigbee.

We do need a veterans' hospital at the earliest possible time, and from what I have been told and briefed on the matter of Providence, I can think of no better way to get started fiscally in saving money. I realize the deficit is a very big problem and there must be some way it can be taken care of. Let's don't do it at the expense of veterans.

We are willing to do our part, but let's don't take the deficit matter to the extent of cutting care for those who have served in the Armed Forces of our Nation. Korea and Vietnam veterans will soon, before you know it, be involved in this particular age group also.

Congressman Shelby, and you distinguished members of the Congress and our good local Congressman, Sonny Callahan, thank you for letting me appear before you briefly, and I would like to file this for the record, if you don't mind.

[The statement of Governor Wallace appears on p. 132.]

Mr. SHELBY. That will be submitted for the record without objection, Governor Wallace, and if you have any additional comments you want to make a part of the record, we will leave it open for 7 days.

Governor WALLACE. Well, I am just happy to be here with you, Congressman Mollohan, Congressman Dowdy, and Congressman Callahan.

Mr. SHELBY. Governor, we want to say we appreciate your coming. I know when I first went to the legislature how you led the fight as the Governor to bring the medical school to Mobile. Now, let's work together to bring this VA facility to Mobile.

Governor WALLACE. Thank you Congressman Shelby, and ladies and gentlemen. I am sorry, I meant to mention the medical school here because it came under my administration and I am very proud of it, and it, of course, would be an asset to the matter of a veterans' hospital also.

Mr. SHELBY. Governor, I remember in 1970, when you were running for Governor, you told the people of Mobile County that you were going to bring a medical school here. A lot of people said that wasn't going to happen. You also stated you were going to bring a family practice clinic to Huntsville and to Tuscaloosa. You did, and I believe you will bring the VA here.

We hope to see you later at lunch, Governor, if your time permits.

Governor WALLACE. Yes, Congressman.

Mr. SHELBY. Thank you. Thank you, Billy Joe.

Mr. SHELBY. Let's resume our panel with Dr. Whiddon, Dr. Crawford, and Mr. Clyde Cox. Will you gentlemen please come back up? I appreciate your letting us take Governor Wallace's testimony out

of order; but out of respect to the Governor and the office, I am sure you understand.

Dr. Crawford, if you want to briefly sum up your remarks with regards to this proposal, you may proceed.

STATEMENT OF DR. STANLEY CRAWFORD, DEAN AND VICE PRESIDENT FOR MEDICAL AFFAIRS, UNIVERSITY OF SOUTH ALABAMA

Dr. CRAWFORD. I am intimately familiar with the relationship between VA hospitals and colleges of medicine. When I was serving as dean at the University of Texas in San Antonio, we helped start and develop the Audie Murphy Memorial VA Hospital, which I think the VA system considers as one of its best hospitals.

The close relationship I think is necessary and can only be achieved if there is a close geographic proximity. It is impossible to deal with something 60 or 70 miles away as far as a close affiliation with students, faculty, and research. It just can't be done.

I think the VA is very wise to look to the future and to the geriatric needs of the VA population, but I would just say to you that let's don't relive history. Let's not cut out our affiliation with medical schools in the future just because we are talking about geriatrics. I think geriatrics needs to be considered in quality, it needs to be considered from the educational standpoint and we need to continue this close association with colleges of medicine.

I think there is another reason that it is good to have colleges of medicine associated with VA hospitals and this is we can introduce the student and the resident physician at a time in his career when his thoughts are being formulated and he may look later down the pike to being a physician in the VA system, and if he knows something about it, you have a chance to interest him in that as a possible career and I think this is an added advantage for the VA that most people don't consider.

We like to think we can work out sharing agreements with the VA and did in San Antonio so that these expensive pieces of equipment like magnetic regimen scanners, CAT scanners, body scanners, and so forth, might be shared if neither facility can afford the initial purchase. These things run out of date about every 5 years and you have to repurchase them again, so this is an added advantage, and I would just say the college of medicine here would be very pleased to work with the Veterans' Administration to develop a facility.

Thank you very much.

Mr. SHELBY. Thank you, Dr. Crawford.

Mr. Clyde Cox, associate dean, school of medicine, University of Alabama at Birmingham.

Please briefly sum up your comments regarding this proposal?

STATEMENT OF CLYDE COX, ASSISTANT DEAN, SCHOOL OF MEDICINE, UNIVERSITY OF ALABAMA AT BIRMINGHAM

Mr. Cox. Thank you, Mr. Chairman.

As you know, I represent Jim Pittman, the dean of the University of Alabama School of Medicine today. Dr. Pittman asked me to tell you that he appreciated very much your invitation to attend

and regretted his inability to do so. He has prepared a statement which is quite brief, about 4 minutes. If you like, I can read it——

Mr. SHELBY. Without objection, Dean Pittman's statement will be inserted in the record.

Mr. COX. May I take this opportunity, Mr. Chairman, to emphasize the value to both parties as relates to sharing, as stated by Dr. Crawford. Sharing in the VA hospital system was developed at the Birmingham VA Hospital in 1971 while I was the VA Hospital Director. May I cite one example. When Dr. John Kirklin came to the University of Alabama School of Medicine as chairman of the Department of Surgery, he established a program of cardiovascular surgery which was completely located in the university hospital. About the same time, Dr. Gil Diethelm established a kidney transplant program, all of which was located in the VA hospital. These two programs provided services for both veterans and nonveterans alike under the authority of a formal sharing agreement, one of the first developed in the Veterans' Administration. Not only were these services available both to veterans and nonveterans, but they were provided without the need for duplicating very costly programs.

Mr. SHELBY. Sir, what you are basically saying, isn't it, is that you have had, because the VA Hospital in Birmingham is located in the medical complex of the University of Alabama Hospital and the Medical School, tremendous research and teaching capability that you wouldn't have had otherwise?

Mr. COX. Precisely, Mr. Chairman.

Mr. SHELBY. This is something that we would have in Mobile if we were to acquire this hospital near the medical school that already exists, is that right?

Mr. COX. That is correct. I would like to give you an example.

Mr. SHELBY. You go right ahead.

Mr. COX. The UAB cardiovascular surgical program under Dr. Kirklin, while being located in the university, was meeting the needs of all the veterans needing this service in Alabama and surrounding States. The success and high quality of this program became so well known that for several years the VA hospital in Birmingham was the referral hospital for cardiovascular veteran-patients all over the Nation. This was a VA central office action.

The transplant program, located in the VA hospital, performed the first kidney transplant in the State of Alabama and was on a service-connected veteran. This veteran was a bulldozer operator. After his transplant, he continued to operate his bulldozer for the next 10 years and had a happy, normal life. He died of a heart attack, while his kidneys were still satifactorily functioning. This is just an example of things that can only happen when you build or acquire a tertiary VA medical center close to a school of medicine.

[The statement of Dr. Jim Pittman appears on p. 135.]

Mr. SHELBY. Mr. Mollohan, do you have any questions of the panel?

Mr. MOLLOHAN. No, thank you, Mr. Chairman.

Mr. SHELBY. Do you have any questions, anyone?

Thank you for your testimony and coming here today.

Mr. SHELBY. Our next panel is going to be Dr. Daniel Sullivan, chairman, health committee, Mobile Area Chamber of Commerce;

Mr. William J. Hearin, Publisher, the Mobile Press Register; Hon. Ann Bedsole, State senate, Alabama, Mobile County; and Douglas Wickes, county commissioner, county of Mobile.

Senator Bedsole, and gentlemen, would you please come forward?

Your written testimony will be submitted for the record and be made a part of the record without objection.

Please sum up your oral testimony as briefly as possible because we have many other witnesses. You can see the intensity of the hearing as it goes along and the interest in it.

Senator Bedsole.

STATEMENTS OF A PANEL CONSISTING OF HON. ANN BEDSOLE, STATE SENATE, ALABAMA, MOBILE COUNTY; WILLIAM J. HEARIN, PUBLISHER, MOBILE PRESS REGISTER; AND DR. DANIEL F. SULLIVAN, CHAIRMAN, HEALTH COMMITTEE, MOBILE AREA CHAMBER OF COMMERCE

STATEMENT OF HON. ANN BEDSOLE

Ms. BEDSOLE. Thank you, Mr. Chairman, Mr. Mollohan, Mr. Dowdy, and Mr. Callahan.

I am an Alabama State senator and I serve on the veterans' affairs committee in our State senate. I have been concerned and involved with the affairs of veterans for some time, particularly with the health care problems and I have got a matter of interest that I wanted to bring to you that I do not think has been covered up to this point.

Our State department of veterans' affairs has just paid over $60,000 to Ernst & Whinney for a thorough study of the need for State veterans' homes in Alabama. Since Alabama has no veterans' homes at all, the study identified more than 1,000 beds needed in south Alabama. For this reason, Mobile was placed No. 1 on the site selection list. The preliminary site ranking was based on Mobile's having, among other items of criteria, the second largest concentration of veterans in Alabama, and, in fact, in all of district 10.

In the study that I think you all are familiar with, "Caring for the Older Veterans," it was noted that while the VA has only 15,000 veterans under long-term care today, in 15 years that number will explode to 760,000. Not only the Veterans' Administration but the State of Alabama also must respond to those needs.

One important part of the Providence complex is a 126-bed school of nursing, which I hope you all were able to see this morning. Used as a nursing home facility, in conjunction with an acute care VA hospital on that site, I believe this would be one of the most exceptional health care complexes in the Nation.

Alabama will be vitally interested in this facility when this project succeeds and I assure you, as I know Governor Wallace would, that we are fully supportive of this project and are determined to see our veterans better served by the VA.

I also serve on the health committee of Mobile United and they have passed a resolution which they asked me to present to you. In the interest of time, I would like to just summarize it and I will give you a copy of it.

Mr. SHELBY. We will submit it for the record if you will present it to Mr. McDonell here.

Go ahead and summarize it, but we will put it in the record in its totality.[1]

Ms. BEDSOLE. All right. First of all, they describe what kind of organization Mobile United is. It is an organization that reaches into every aspect of this community and they also tell you that the sole purpose is to seek a better quality of life for all the citizens of the area. They point out the cost-saving benefit of $24 million for Providence as opposed to constructing a new facility at a cost of $90 to $100 million. I don't think they had heard that $400 million figure, and they also point out that the largest concentration of veterans of any area along the coast is in this county and the adjacent counties, and that the Providence site has immediate access to the services of the medical school, and they end by saying,

> Therefore, be it resolved, that the membership of Mobile United go on record requesting that the Veterans' Administration give Mobile the opportunity to serve the courageous veterans of this area by serving as the home of the newest Veterans' Hospital site on the Gulf Coast.

And they passed this on March 5, 1985.

Mr. SHELBY. Thank you, Senator.

[The statement of Hon. Ann Bedsole appears on p. 165.]

Mr. SHELBY. Our next witness is Mr. William J. Hearin, publisher of the Mobile Press Register. Mr. Hearin, as I said earlier, your written testimony will be submitted to the record in its entirety without objection. You may proceed, sir.

STATEMENT OF WILLIAM J. HEARIN

Mr. HEARIN. Well, gentlemen, I am sorry to say that Senator Bedsole took away half of my speech that I was going to make this morning, but one thing that kind of reminds us of the commercial, "Where is the beef?", where are the veterans? I think the veterans are right in this area within 75 miles of Providence Hospital.

I have been around here a long time as publisher of the paper and I have never seen Mobile more united over getting the veterans' hospital in Mobile. They go off in different directions sometimes, but this is one thing they are united on and I am proud of them for it, because no one likes to save money more than I do. I think this is one time the Government can save money.

That sounds like some of our friends around here know I like to save money. People have been leaving off the gas field in Mobile Bay. We have talked about the Tennessee-Tombigbee, and I think that is going to be one of the greatest things that ever happened here, but I honestly believe the gas is going to be greater.

The oil companies have spent three-quarters of a billion dollars just to lease the land to drill on. I think we have nine wells down there. Every one of them very profitable wells, up to 10 to 34 million cubic feet of gas a day each. I think we will have two more wells that will come in in the next 2 months.

You will find in the paper each Sunday where they are waiting on rigs to start other wells. They have leased land on the industrial canals to start, they are really going to work in the bay because they can run their boats out of here instead of out of Louisiana, so

[1] See p. 167.

I think that is the biggest future and that is going to bring a lot of people to this area we haven't counted on.

Mr. SHELBY. Mr. Hearin, I believe that this fact was ignored in the VA report. He never mentioned the energy production in this area which will mean tremendous growth potential in the future.

Mr. HEARIN. Well, there is no wonder they don't want to mention it, because I think that is going to bring industry here because of the cheap fuel. It is right here in the backyard. I want to thank you all for coming down. Like I always tell my political friends who come to Mobile, if you can't go to Heaven, come to Mobile; this is the second best place. I would also like to say if anybody thinks they want to vote against this thing, Providence, don't let them do it until they come down here and see what they are voting for.

Thank you.

STATEMENT OF DR. DANIEL F. SULLIVAN

Dr. SULLIVAN. I am Dan Sullivan. I am representing the Chamber Health Committee. I also have a couple of other hats. I am a veteran, and I have practiced medicine in this community for over 35 years and have used the Providence Hospital all of this time, and know what an excellent buy they are getting.

There are a few things that have been overlooked that I would like to bring up. First of all, where the gentleman said the veterans are decreasing, he is killing us off in a hurry. Really, he has to stop and look that by 1990, every male over 65, 65 or over, one out of every two will be VA eligible. We all know that anybody over 65 requires about twice as much hospitalization as a male from 45 to 64. These figures were sort of jumped over and it is important, but other than that, all I can say is that the medical community, the community itself just welcomes and hopes that they will save this $70 million and give good care to the veterans.

One other thing, the medical school is essential to good care. This, everybody should recognize.

Mr. SHELBY. It is also essential for research.

Mr. SHELBY. On behalf of the committee, I appreciate all of your testimony. Mr. Hearin, I know that, as a publisher, you do focus in on Mobile and everything about it. In particular, I appreciate your statement that Mobile is united on this hospital acquisition. I also appreciate your comments on the energy potential situation and possible population growth.

Senator Bedsole and Doctor Sullivan, we also appreciate your coming before us.

Mr. SHELBY. Our next panel will consist of service organizations. Mr. Frank Wilkes, director, Alabama Department of Veterans' Affairs; Mr. Robert Bosarge, Buddy Poppy Committee chairman, Department of Alabama Veterans of Foreign Wars; Mr. John Tyson, no stranger to Mobile and a prominent attorney, senior vice commander, Department of Alabama, the American Legion; Mr. James Jackson, junior vice commander, fourth district, Department of Alabama Disabled American Veterans and Mr. Robert Payne, District 9, Department of Alabama, Veterans of Foreign Wars.

Gentlemen, please come up here. Your written testimony will be submitted in its entirety for the record because we want it as part

of this official proceeding. Please briefly sum up your remarks. I know why you are here, but we want to hear from you.

Mr. TYSON. Could I correct the record?

Mr. SHELBY. Yes, sir.

Mr. TYSON. I got promoted to commander a long time ago and my senior vice is looking at me.

Mr. SHELBY. John Tyson is correct. He is the commander. We are proud of him. I know he has worked diligently for the Mobile veterans. Excuse me.

Mr. TYSON. Oh, that is fine, sir.

STATEMENT OF A PANEL CONSISTING OF FRANK D. WILKES, DIRECTOR, ALABAMA DEPARTMENT OF VETERANS' AFFAIRS; ROBERT BOSARGE, BUDDY POPPY COMMITTEE CHAIRMAN, DEPARTMENT OF ALABAMA, VETERANS OF FOREIGN WARS; JOHN TYSON, COMMANDER, DEPARTMENT OF ALABAMA, THE AMERICAN LEGION; JAMES JACKSON, SENIOR VICE COMMANDER, FOURTH DISTRICT, DEPARTMENT OF ALABAMA, DISABLED AMERICAN VETERANS; AND ROBERT PAYNE, DISTRICT 9, DEPARTMENT OF ALABAMA, VETERANS OF FOREIGN WARS

STATEMENT OF FRANK D. WILKES

Mr. WILKES. Mr. Chairman, Congressman Dowdy, Congressman Callahan, good morning and welcome to Alabama. As the director of the Alabama Department of Veterans' Affairs, we have the privilege of serving our State's 437,000 veterans plus their dependents. I am extremely proud to have the opportunity to come before this distinguished committee today to share my views on the issue dealing with Providence Hospital in Mobile.

I would like to take just a couple of seconds time if I could to introduce several of the distinguished members of the State board of veterans' affairs that have traveled here from all over the State.

Mr. SHELBY. You may proceed.

Mr. WILKES. Mr. Warren S. Reece, Jr., vice chairman of the board representing the Veterans of Foreign Wars. [Applause.]

Hoyt E. Fan, representing the American Legion. [Applause.]

Mr. William F. Green, representing the Disabled American Veterans. [Applause.]

Mr. Oscar Bates, representing the Veterans of Foreign Wars. [Applause.]

Mr. Lewis McRay, representing the American Legion. [Applause.]

Mr. Buddy Ennis, representing the Disabled American Veterans. [Applause.]

And Judge Telfair Masterin, also representing the Veterans of Foreign Wars. [Applause.]

I am told, Mr. Chairman, that Judge Masterin had to go back to court.

VOICE. Judge Masterin expressed that we ask that he be excused, he had to go to court.

Mr. SHELBY. Thank you, Mr. Reece.

Mr. WILKES. I am going to have several pages of testimony to present, Mr. Chairman, and, at your request, I will try to summarize in brief some of the comments.

Mr. SHELBY. We want to give the Florida panel a little time. Out of courtesy, I wouldn't want to cut them out completely.

Mr. WILKES. Yes, sir; I understand that fully. We are here to serve all veterans and their needs and I think that is what we should be doing.

Mr. SHELBY. Sure.

Mr. WILKES. It is a known fact that the medical and long-term health care needs of our aging veteran population in this whole region is escalating rapidly and as VA Administrator Harry Walters himself states, the question is not whether the VA will meet these needs, but how? In addition, one of the most significant findings of the Grace Commission report was that the Nation's health care commitments to its veterans can be met at a substantially less cost over the long run if the current VA policy framework is adjusted.

Obviously, the VA framework does need to be adjusted to address the future health care services in the most economically and fiscally sound manner.

The major issue in the decision as to whether a VA facility will go to Mobile or the Panhandle of Florida is that of need for such a facility and that need is now, Mr. Chairman.

Under the present 10-year timeframe for new VA construction, it will be 1995 before the Florida Panhandle can be established. Providence is available next year, 1986.

In addition, with the current conditions of the tremendous Federal budget deficits and apparent cutback or possible freezing of Federal spending, it is highly unlikely that the probably $100 million construction cost to establish a Florida facility could realistically be appropriated.

The Alabama Department of Veterans' Affairs did conduct an in-depth survey which was alluded to, I think, earlier by the Senator from Mobile indicating that there is a great need to have long-term health care facilities in the State of Alabama to serve our aging veteran population.

Mobile came out No. 1 in that study because of its drastically increasing veteran population. In our study, the demographic analysis of our studies reflected some very interesting trends that will be related to Alabama's veterans. The over age 65 State veterans population experienced a 53-percent growth from 1980 to 1984 and it is expected to grow another 100 percent by the year 1994.

To substantiate the current great demands for future VA nursing home and long-term health care for our veterans in this whole region, the April 1984 Congressional Budget Office study entitled, "Veterans' Administration Health Care Planing for Future Years" does stipulate that by the year 2000, the demand for nursing home care could more than double that of 1982.

In addition, the CBO report indicated that if the average hospital lengths of stay remained at the same level in 1990 as now, the demand for nursing home care would increase by about 40 percent with a proportionate care given veterans 65 and older rising a drastic 60 to 78 percent.

Gentlemen, for your information, I have been informed by the Providence officials that should the Veterans' Administration acquire their facility, they would gladly make arrangements for the

VA to take over the current existing 126-bed nursing home within the next 3 months time and I think that is a great idea, Mr. Chairman.

An additional important issue that has not been addressed here this morning, Mr. Chairman, is the ever-increasing growing population of our female veterans. They are here in great numbers in this entire region. Providence currently has a modern OB–GYN department that has 52 operational beds and undoubtedly, and unquestionably, these services are presently unavailable in this entire area.

Mr. David Stockman, the Director of Office of Management and Budget in a report to the U.S. Senate Committee on the Budget offered eight possible areas for future structural reforms and major budget savings. One area centered on veterans' health care. Mr. Stockman stated, "In view of the ever-increasing costs of veterans' health care, one option to continue to provide the necessary medical services to our veterans is to make wider use of the excess facilities in the private health care systems."

With this thought in mind, the officials from Providence Hospital are willing to personally commit to an agreeable leasing arrangement with the Veterans' Administration of providing 50 to 100 acute-care beds immediately to serve urgent medical needs of the veterans in this entire region.

The Providence officials would happily agree to make arrangements with the VA for 90 percent of their current VA medical care costs.

Mr. Chairman, all of the reports from Washington have totally supported this endeavor. They are all positive. In 1984, the VA Department of Budget and Medicine and Office of Construction conducted a thorough facilities survey of Providence and many, many other studies were made. I do feel that this entire project does deserve your careful consideration. Myself, the State Board of Veterans' Affairs, and the entire Department of Veterans' Affairs, the Governor, and others in State government, are totally committed and I think that once you have reviwed the information presented here today, you will fully realize that Providence is a feasibly and economically sound endeavor. I am truly convinced that Providence is totally justifiable and would serve the medical best interest of our veterans in this entire area.

Thank you, sir.

Mr. SHELBY. Thank you.

[The statement of Mr. Wilkes appears on p. 168.]

Mr. SHELBY. Commander Tyson, do you have any comments?

STATEMENT OF COMDR. JOHN TYSON

Mr. TYSON. Mr. Chairman, and members of the panel, I know you all get tired of us traipsing in your office and asking about this need.

Richard, when you were a little boy, back in the year 1954, your post Senator—I call him Senator Callahan—Representative Callahan, adopted a resolution expressing the dire need in this area for medical care for veterans. That is the first resolution I can remember. There may be a few here older than I that can remember even

before then. This need has increased over the years. In this current endeavor that where the Providence Hospital virtually was a God-given thing to us. As you gentlemen toured that hospital, I know that you expressed the unbelief as have the other people that have come in here from Washington that have looked at it, from Mr. Casteel to Mr. Principi, to all of the other people of the VA saying, my goodness, somebody made a terrible mistake giving up this modern, up-to-date facility, complete with nursing rooms, nursing home, nursing school, all of these medical equipment things that are not even available in most parts of the United States.

Nonetheless, the good sister out there said to us, she said, "Even though we have made this decision and embarked on another program to build a hospital elsewhere, this facility can best serve humanity and the veterans and we will hold it open for 2 years for you to make an effort to do this."

Everybody, as Bill Hearin said, in the veterans' community and in the community at large, from Mississippi, Mr. Dowdy, from the Panhandle of Florida, from south Alabama, from all over, have given us encouragement and support.

We have done numerous studies, we have had the Veterans' Administration down here. When the MEDIPP report came out and Mr. Bickerstaff submitted that report that really caused you to formulate this committee and come here, we were shocked beyond belief because that report apparently ignored every document that had been sent to them. If you use just plain reasoning, it is very difficult for anyone to understand how the second largest metropolitan area on the entire gulf coast, the largest veterans population area between New Orleans and Jacksonville, the center of the gulf coast urbanizing belt, the center of the gulf coast crescent, the second largest city in the State of Alabama has received no consideration whatever.

I have a summary of the criticism of the MEDIPP study on Providence Hospital, for example, to submit to you gentlemen. Our studies indicate first, and I made this commitment to Chairman "Sonny" Montgomery, he is an old Legionnaire and I see him on a first name basis and saw him in Washington up there, we were all surrounding him, I said, "It will not hurt Mississippi one bit." I am kind of like the Baptist preacher telling his congregation, you don't have to worry about proselyting anybody, we have got plenty of unchurch to go around. We have got veterans here, we have got them in west Florida, we have got them down in south Alabama, the need is so absolutely acute that this will augment what you gentlemen have done in Mississippi.

We find today that we cannot get people in Mississippi. We were down there for the dedication, Mr. Dowdy, for a new facility down there. It is gorgeous, it is wonderful, but only last night—Joe Langton can tell you, and maybe I am stealing some of your thunder, a busload of veterans that had to get in a hospital went down there, one got in, the rest had to go to some public facility. Where was it? It was some facility outside.

The district 10 that is arbitrarily drawn by the Veterans' Administration, I guess they have got to draw jurisdictional lines for some reason, is a myth.

We, in west Florida, are all considered, counted as one. Back when I was in the legislature in the olden days, as my kids say, we tried to annex west Florida. While they didn't choose to come, we focused some attention on west Florida, so they got I-10 built and they are our brothers. We call them lower Alabamians, and they need help too.

If you could squeeze the President and the rest of them and say let the military open up some of their base hospitals and take care of our veterans, fine.

Earl Hutto told me that he was able to get that fine facility that will be underway shortly in Pensacola and maybe another one can be, it is an outpatient thing, at the center here; but we need quality care and we need it now.

As has been alluded to, the huge discoveries of oil and gas, this Tennessee-Tombigbee, the whole Sun Belt region down in the gulf coast is growing. Every time it snows up north, they come south. You know that. And we are going to have more than necessary.

I talked to one of the VA people on a complaint that caused the doctors at the hospital over there, many of them are foreign born—we are not criticizing foreign-born doctors, it is hard to get good doctors, and because they can't speak the language, it makes it a little bearing, so the VA said, well, we will get you an interpreter. Now that is not quality medical care, and what we have here given to us by the good Lord Himself, in Mobile, AL, is the finest facility that you can find anywhere. They are throwing in a 126-bed hospital that even by Stockman's report, or somebody's report, shows that is worth millions and millions of dollars, and that comes just as a bonus and it is ready now.

I know, and I know I speak for these other veterans here that when you have a heart catheterization or if you have bone cancer, if you have an agent orange, or if you have a brain tumor, or if you have something that requires tertiary treatment, I want to go to the best and the best has to be by a medical school.

We will support west Florida. We know they have a need. I know they have to take their patients, like we do, down to New Orleans for tertiary care, or to Jackson, MI, that fine hospital, and wait around. I have them sitting all around the room that can't get up there, and they have to go to Birmingham, AL. So what we are asking here complements Biloxi and Gulfport. You go down to Gulfport and I will guarantee you that the majority of the people in Gulfport are from New Orleans. They are all veterans. They need the care. So that line of district 10 doesn't mean anything. You tell "Sonny" Montgomery that we hold him with reverence. That the need is here for all along the gulf coast. We thank you gentlemen for coming down here.

Sonny, I told you coming in, I said, "You know, you have just got up there and you have already got a subcommittee and a forum here in Mobile, you are doing well, Sonny." He is a member of post 3 American Legion.

With your permission, I will submit the criticism of the MEDIPP procedure to start with.[1]

---

[1] See p. 174.

Mr. SHELBY. Without objection, it will be made a part of the record. Please give it to Mr. McDonell.

Mr. TYSON. Thank you, and then one last item I do want to put in, there is a study that is put out that is called, "The Aging Veteran, Uncounted Cost, Unkept Promises," published by the American Legion. I want you all to read that. There is one for Mississippi too.

Mr. SHELBY. Without objection, we will make that a part of the record also.[1]

Mr. TYSON. All right, thank you. The American Legion stands four square behind this all over the State of Alabama. The legislature has passed a resolution, we have got Senators, Senator Bill Minton out here, he has been supporting us all the way and some of the representatives had to leave, and we have got a lot of people that would like to tell you a lot, but that here and now is where we want it and we love west Florida and southern Mississippi and we are all together.

Thank you.

Mr. SHELBY. Do any of you other gentlemen have any comments?

Yes, sir, go ahead, as briefly as possible, however, because I did tell the Florida people I would give them a little time.

STATEMENT OF ROBERT BOSARGE

Mr. BOSARGE. Thank you, Mr. Chairman.

I have a brief summary I will also submit here which has been proposed. This is——

Mr. SHELBY. Your written testimony will be submitted for the record without objection.

Mr. BOSARGE. OK, what has not been brought out here, Mr. Chairman, is the report here. I don't know where District 10 got their statistics from, but we don't want to go into that too much.

This is a report put out by the VA. It is a visit from the VA Hospital in Biloxi. I understand they say is not overcrowded and can take care of anybody and it has been coming over here since 1978, it is a 9-page letter. This is put out by the VA, not by us, and it has not been submitted before. I would like to have it submitted at the present time.

Mr. SHELBY. It will be made a part of the record without objection. Please give it to our staff member Mr. McDonell.

Mr. BOSARGE. Thank you, sir.

[The statement of Mr. Bosarge appears on p. 205.]

Mr. SHELBY. Yes, sir; go ahead. You may proceed.

STATEMENT OF JAMES JACKSON

Mr. JACKSON. Congressman Shelby, it is a pleasure to meet you again as I did in Washington, DC, with the original committee.

Mr. SHELBY. It is a pleasure for me and my colleagues to have you here before this committee.

Mr. JACKSON. It is a pleasure to meet you gentlemen, also.

I, too, have been promoted to senior vice commander, the Department of Alabama, and I have as a guest our national service offi-

[1] Retained in committee files.

cer, Billy Black, who will, with your permission, submit a written report at a later date.

Mr. SHELBY. We will leave the record open for 7 days. If you will just mail it to me in Washington, I will make it a part of the hearing record.

Mr. JACKSON. Thank you very kindly.

The main thing I have to say, everything has been said basically that has emphasized our position with the Disabled American Veterans along this Gulf Coast, the statistics plainly show that the need is rising. I, myself, had a heart attack, and thank the Lord for Providence, I couldn't get any place else and that is why I am sitting here today, because of their acute service and immediate service. I couldn't get to Biloxi and I couldn't get to the VA Hospital or the Military Hospital which I am eligible to go to after 23½ years service.

I am a life member of the Disabled American Veterans and Veterans of Foreign Wars, and a member of the American Legion. I served with the mayor's Council for the Handicapped of the city of Mobile for the past few years and know the critical need here in this area.

Since my retirement in 1979, all I have done is work with the veterans and the handicapped throughout this entire State.

There are a number of statistics and being a pretty decent mathematician, myself, you can make statistics read anything you want them to read, but this area is growing at over the national average of population. Our veterans are aging, myself as well, and as has been emphasized previously, more care is needed, and immediate care.

The article that I had placed in the paper and I will also submit to the record——

Mr. SHELBY. It will be admitted without objection. Please give it to the staff.[1]

Mr. JACKSON [continuing]. Use of facilities for a Veterans' Hospital, and I ask the question, "Do you believe our government should spend excess millions for new construction for medical care for veterans when an excellent medical facility is available? Would you use such a VA medical facility if eligible?" And, as you well know, 60 percent or more of the veterans will use VA facilities if they are available. But this is the problem in the Gulf Coast area in the Panhandle of Florida. There are many, many veterans that are still working, that fortunately can hold a job, and use their own private insurances and the retirees that use DOD facilities are not even being considered in these statistics.

There was, too, this article that I just mentioned, there was not one negative answer and, Mr. Hearin can vouch for it, the paper was swamped with answers, and I would just like to say, please, consider the evidence that we have given you. Take a positive step forward for the veterans as you have in the past, but make this a pilot program and it will work, we will make it work.

Thank you.

Mr. SHELBY. Thank you.

---

[1] Not received at time of publication.

[The statement of Mr. Jackson appears on p. 217.]

STATEMENT OF ROBERT PAYNE

Mr. PAYNE. I am sitting in a group that is tough to follow, but I will be the last one. I must identify myself. I am a service officer with the Veterans of Foreign Wars, district 9, post 49.

Mr. SHELBY. So you are dealing with the veterans every day?

Mr. PAYNE. On a day-to-day basis, 7 days a week. I may ask that I have the opportunity to rewrite what I have here and submit it through the mail.

Mr. SHELBY. If you want to do that and mail it to me in Washington, it will be made a part of the record.

Mr. PAYNE. Thank you, but I would like to make some comments.

Mr. SHELBY. You go right ahead.

Mr. PAYNE. My contact with the area veterans is on a 7-day-a-week basis. My office, if you want to call it that, is in my home and I deal with the problems of area veterans at the rate of 10 per day. It does not seem like a large number, but I am talking about an hour to an hour and a half with each one of them.

Most of these contacts concern some form of hospital or medical need of the veteran and it is most frustrating, to say the least, not to be able to meet most of the needs.

It has been stated by factfinders that the area veterans do not use the facilities that are available at Biloxi and we know why. The available facilities are just not available most of the time.

On Wednesday, March 13, just 2 days ago, I visited a veteran in a local hospital. He is retired from the Air Force. We tried to get him hospital space. We tried Keesler Field, no bed. We tried Pensacola, and I made a note here they had 40 unoccupied beds, I understand, but there was no bed available for this retired veteran. Then we tried the VA in Biloxi, no bed. We could not get the man transported to Biloxi without approval, unless he went down there on speculation.

The doctors in our community have thrown up their hands in utter disgust when they try to contact the Biloxi doctors to see if they can get someone—because these same old answers, no bed. I am not criticizing the people that are working in the VA, not in any way. They are my friends. The runaround though that is given them because of no bed space is just atrocious.

I transport veterans to Biloxi sometimes three and four times a week, three and four people to the car. Sometimes I will take a van of eight or nine down there and when they see me coming in the door, they say, "Here's Payne again with another load."

Mainly I take these people down there because they don't have any way to get there. Transportation is bad between here and Biloxi; if they ride the bus, it is a whole day, from 6 o'clock in the morning until 11 o'clock at night, and that is pretty bad—to send a man who is sick on a bus down to Biloxi.

It would be all right if he could get on the bus and get there, but he can't do that, so someone has to take them. So many of them are at a point now where they don't have an automobile and if

they had an automobile they couldn't drive it, they are too sick, so we try to take over.

When a veteran does go to Biloxi, he is seen by a doctor that day, but getting treated or getting his medical needs taken care of that day is not always the case. He will be sent back for further consultation 2 weeks from now or another one a month from now. Just recently I took a man to Biloxi, he was examined and scheduled for the cardio committee. I brought him home and he was dead within 48 hours.

Recently I took another veteran to Biloxi, service connected, 60 percent, and by the way he has been paying his own medical bills since 1946, and he has been 60 percent since then. He has never filed a further claim with the VA until recently and it was at my urging that we are doing it. The doctor told him in my presence, I heard the statement, "I am sorry"—and he was very kind when he told him this—"we don't have anyone here to take care of your needs. You will have to go somewhere else or keep your present medical program."

Now, I can understand why he said that because he did not have the availability of the specialist that was there. Now at this point, anger starts to fill in and you get angry.

In January of last year I took a 90-year-old veteran of World War I and World War II, with some 30-odd years of service. He needed some medical help. When I got there, I was not allowed in the examining room along with the veteran, although at the initial statement in the interview, I had suggested that the man could be a little senile and maybe not able to talk for himself. A few minutes later he was wheeled out and the nurse said he could go home. I asked how, and she said that the veteran said there was nothing wrong with him. Of course he couldn't stand, he couldn't walk, and he talked in riddles. Well, I went to the patient representative who is a beautiful person, both in complexion and in manner, and we went to the director's office and they sent someone down. We talked to another doctor and our veteran was admitted, he was examined and admitted. In 4 weeks I went after him, brought him home, and today he is still 90 years old, well, he is 91 now, his physical condition is great because he had 4 weeks of needed hospitalization. His mind is still the way it was but he is at least physically—now he is service connected and his problem was service connected.

I know that the medical community around Mobile could answer most, if not all, of the problems that we have with medical service for the veteran. I am not talking of someone who has heard someone talk about this, I am talking about what I see every day. The average veteran to whom I talk is asking for help because all other avenues are closed. He did not create the Nation's money problems or create the deficit. In most cases, these men have done everything possible to keep from being a burden on the country.

Most feel honored that they offered their lives for their country when they were needed. Now, when they need help, their country is running away from them, through medical care—or the lack of.

I have the greatest respect for the people working in the VA hospitals. They, for the most part, have always treated me with the utmost care and concern. However, when you are told that there is

not a bed, when you are told that medicine or medical care is not available, kindness will not be the salve, no matter how kindly you are informed.

This is my 18th year as a service officer, and I have been in this particular area for 14 of those 18 years. I have seen the needs grow by leaps and bounds. My workload has been doubling every 2 months for the past year to the point where I just can't handle anymore.

We are happy to be of service to the many veterans in the area, but we cannot be expected to carry the full load for the VA. I speak only for my organization, the VFW. The other service organizations are all working in the same fashion. I am not alone. We are all working out here the same way and we know that a lot of our veterans could be saved, the lives could be saved if we just had a little closer, more trained medical people.

I have got to ask a couple of questions and this is part of the statement. Have you ever put someone in your car and headed out for a 60-mile trip in an attempt to get that person to the hospital and feared that the next breath would be his last? I am looking at the people in the Panhandle of Florida that have to go 120 miles or 140 miles. At least we would be 60 miles closer for them.

Have you ever stood with a family who had no money, five little mouths to feed, their breadwinner sick for several months, but not able to get into a VA hospital and no other medical help available?

Have you ever had a widow come to you and say that her husband probably would be alive today if only the doctors would have examined him for his complaint instead of arbitrarily sending him to the mental ward and then he died within 48 hours? That happened recently.

Well, I have. I have gone through this, and I go through it almost on a day-to-day basis.

I went through my files Wednesday evening and counted the veterans I have transported to Biloxi in the last 6 months and helped bury within just a few weeks. There were 11 of them. That is almost two a month that I took to the hospital that died and we had to bury them, and this is not the fault of the treatment they got at the hospital. I am not saying that. It is just that they should have had closer treatment, or more adequate treatment, to get them through the hump. There is no reason for this. Money can be appropriated for defense, I don't disagree with that. Money for foreign aid, and I don't disagree with that, but not at the expense of our first line of defense, the American veteran who has served his country proudly and asked for so little.

How are you going to tell the future soldiers, sailors, marines, Coast Guard and Air Force men, hey, we are not going to keep our promise to you, we only want you for now?

Thank you.

Mr. SHELBY. We appreciate your testimony.

We appreciate all of your comments. Your remarks have been well taken. We have another panel, and we are going to try to hurry up because we have the Florida people.

Mr. Randy Knepper is with Congressman Earl Hutto from Florida. Also, at the same time I want to bring up Harry McDonald, Jr., commander, Department of Florida, Disabled American Veterans;

Mr. David Carter, executive director, Northwest Florida/Big Ben Health Council; Mr. Simon Stover, director of Veterans' Affairs, State of Florida; and Mr. Jim Hixson, assistant service officer, Bay County, FL, Veterans' Service Office.

STATEMENT OF A PANEL CONSISTING OF RANDY KNEPPER, ASSISTANT TO HON. EARL HUTTO; SIMON F. STOVER, DIRECTOR OF VETERANS' AFFAIRS, STATE OF FLORIDA; HARRY McDONALD, JR., COMMANDER, DEPARTMENT OF FLORIDA, DISABLED AMERICAN VETERANS; DAVID CARTER, EXECUTIVE DIRECTOR, NORTHWEST FLORIDA/BIG BEN HEALTH COUNCIL; AND JIM H. HIXSON, ASSISTANT SERVICE OFFICER, BAY COUNTY, FL., VETERANS' SERVICE OFFICE

Mr. SHELBY. Congressman Hutto, has submitted a written statement. I have a copy, and it will be made a part of the record without objection.

Randy, I know you work with Congressman Hutto. We have a lot of respect for you. We are pressed for time because we are trying to get to a luncheon with the Governor and we are already 30 minutes late. Your testimony will be submitted for the record without objection.

Mr. KNEPPER. I would like to ask that the Congressman be able to revise—

Mr. SHELBY. Speak into the mike.

Mr. KNEPPER. I would like to be able to revise this.

Mr. SHELBY. You will have the opportunity to revise and extend your remarks for a week. Is that OK?

Mr. KNEPPER. That will be fine.

Mr. SHELBY. And also anybody else who wants to.

Mr. KNEPPER. Thank you.

[The statement of Mr. Hutto appears on p. 254.]

Mr. SHELBY. Mr. Stover.

Your written testimony will be submitted for the hearing record in its totality. If you would please briefly sum up your remarks and your concerns.

STATEMENT OF SIMON F. STOVER

Mr. STOVER. Yes, sir; Congressmen and Mr. Chairman, it is a real pleasure for me to be here representing the 1.4 million veterans in Florida.

Mr. SHELBY. Please speak into the mike.

Mr. STOVER. It is a pleasure—I generally don't have a problem with sound, sir. As a marine, people generally hear me.

It is a pleasure for me to be here on behalf of the 1.4 million veterans in the State of Florida, and we do appreciate you allowing us this time to present testimony.

Along with the additional remarks that you have already approved for submission, sir, I have four letters that I would like to include in the record with my statement.

Mr. SHELBY. They will be submitted for the record without objection [1] if you will please hand them to the staff member, Mr. McDonell.

---

[1] See p. 266.

Mr. STOVER. There are five areas, most of which have been covered, that I would like to go over real quick.

One is the Florida support for the medical district 10 MEDIPP plan, and that is the siting of a hospital somewhere in the Panhandle of Florida versus the Mobile area.

One of the reasons for this is that under the present system, and with the map that I have here, sir, Florida Panhandle veterans now that are outside a 100-mile radius of any facility that exists now is 95,000 veterans.

Mr. DOWDY. What is the blue on there, what does that represent?

Mr. STOVER. That represents Mobile, if the VA purchased the Providence Hospital in Mobile. The black lines represent existing facilities now, a 100-mile radius.

Mr. DOWDY. Is that map going to be made a part of——

Mr. STOVER. Yes, sir.

Mr. SHELBY. I will submit it for the record if no one has any objection.

Mr. STOVER. Yes, sir; that is part of my statement; yes, sir.

Mr. SHELBY. If you will give that to the staff member?

Mr. STOVER. I think you already have that, sir. It is part of the statement—95,000 veterans today are outside a 100-mile radius of the VA facilities.

Mr. DOWDY. What counties now do they reside in?

Mr. STOVER. That would be all of the Panhandle, sir, from Tallahassee westward.

Mr. DOWDY. Have you done any studies to indicate—the blue line, that would be Providence Hospital'

Mr. STOVER. Yes, sir.

Mr. DOWDY. Do you have any studies to indicate how many of that 95,000 would still remain outside the 60-mile radius?

Mr. STOVER. Yes, sir; if Providence Hospital was to open its doors today as a VA facility, 50,000 veterans in the panhandle would still be outside the 100-mile radius.

Mr. DOWDY. A 100-mile radius?

Mr. STOVER. Yes, sir; a 100-mile radius.

Mr. SHELBY. Excuse me, Wayne. Do these drawings include the outpatient clinic at Pensacola? Did you take that into consideration?

Mr. STOVER. No, sir; we are talking about inpatient hospitals.

Mr. SHELBY. OK. Did you take into consideration empty beds that could be shared at Eglin Air Force Base or at Tyndall?

Mr. STOVER. The answer to your question, sir, is no, but if I may elaborate——

Mr. SHELBY. Sure.

Mr. STOVER [continuing]. Just very quickly, on that. The authorized beds at the existing DOD facilities, if you use that figure, there are existing beds, but I can tell you today, sir, as a matter of fact, there are zero beds available at Navy, Pensacola, Eglin, or Tyndall because those are operating beds that they use, vice authorized beds.

Mr. SHELBY. Our understanding is they are not available because they are underutilized like so many DOD functions?

Mr. STOVER. I can't—I have no experience——

Mr. SHELBY. What we are interested in is representing this Nation's taxpayers, veterans, and everybody in utilizing all the facilities—whether they are in Florida, Mississippi, Tennessee, California, or Connecticut.

Mr. STOVER. Yes, sir.

Mr. SHELBY. We have to do it on a shared basis. I want to assure you I want to see that the veterans of the Panhandle of Florida are served—just like the veterans of Mississippi and south Alabama. What we are trying to determine is the best way to do it.

Mr. STOVER. Yes, sir; I understand that, and that is what we care about also.

Mr. SHELBY. Sure.

Mr. STOVER. We care about the veterans and the purpose for this was to show that there would still be a large number of people outside of an inpatient care facility.

Mr. SHELBY. We will study those remarks you have made plus your map. Go ahead.

Mr. STOVER. Thank you. OK, and again we would like to reiterate the drawdown on the Biloxi, Gulfport Hospital and of course, I have heard all of the testimony before and that will be up to you to decide.

The VA figures on veterans in migration from 1975 to 1983 showed that Alabama gained 6,776 veterans while Florida gained 135,992 veterans.

Mr. SHELBY. Where are those 135,000 located?

Mr. STOVER. Believe it or not, sir, they are equally distributed throughout the State.

Mr. SHELBY. Florida is a big State.

Mr. STOVER. Yes, sir.

Mr. SHELBY. How many are in the Florida Panhandle? We would like to see the stats on that.

Mr. STOVER. I can provide you with that, certainly. That is no problem.

The other thing, my last point, sir, is this cost-per-bed that has been brought up today. I wasn't even aware of this until I heard the testimony, but $69,000 per bed is based on the purchase price of the existing building now which houses 350 beds. A VA facility as I understand it would be a 200-bed facility which means the price goes up for this same piece of ground, per bed price, excuse me.

In addition to that, the VA would have a certain amount, and as I understand it, and, again, this is what I have been told, that there would be a large amount of renovation required and that it almost doubles the cost, the purchase price cost for the renovation.

Now, we are looking at somewhere in the neighborhood of $146,000 a bed for Providence Hospital. New construction for nontertiary hospital bed cost for the VA is $150,000, so we are talking about $4,000 difference in beds.

That is all I have, sir. I appreciate very much your allowing us to appear here.

Mr. SHELBY. We appreciate your waiting and we appreciate your courtesy. I want to reiterate again that we are interested in all veterans whether they are in the Florida Panhandle, Mississippi, south Alabama, or wherever. I think that is crucial, and that is why we are here.

Mr. STOVER. Yes, sir; thank you very much.
Mr. SHELBY. Congressman Dowdy, do you have any comments?
Mr. DOWDY. I don't have any comments.
Mr. SHELBY. We appreciate your coming here today.
[The statement of Mr. Stover appears on p. 266.]
Mr. SHELBY. Is there anybody else who has comments? As I said earlier, all of your written testimony will be made a part of the record.

STATEMENT OF HARRY McDONALD, JR.

Mr. MCDONALD. Mr. Chairman, I am Harry McDonald, Commander of the Disabled American Veterans in Florida. I do not have a written presentation to give to you but I do have a few remarks that I would like to make.
Mr. SHELBY. You may proceed.
Mr. MCDONALD. I live in the area of Eglin Air Force Base. I am treated there. I am a 28-year veteran, with military service, a veteran of World War II, Korean, and Vietnam.
You talk about empty beds. The empty beds are non-existent. We have people that are turned away from the hospital at Eglin on a daily basis because they do not have the beds and the facilities to treat them. It is an impacted area and to say that we can put veterans in Eglin Hospital is a myth.
Pensacola, I understand, has a few hospital beds that they do not have open because they do not have the people to man these beds, medical people.
The same problem, 40 beds are 40 beds, but I can't see that this handles the problem of the 150,000 veterans in the panhandle.
Our problem is distance. When I have people that must travel 200 miles on secondary roads, farm roads, two lanes, have an 8 o'clock appointment, say, in Montgomery, they must leave the night before. There is no place for them to stay. They must do this at their own expense. When you get to Montgomery, the chances are they are transferred to Birmingham by Government vehicle. They go to Birmingham, they spend the day, and along about 4 o'clock in the afternoon they send them back to Montgomery, drop them off and say go home. Then they are faced with another 200 miles.
The problem is where is the care most needed? I submit to you that the care is most needed centralized in the Panhandle of Florida. I am not putting Alabama down. I have been called "that member of the Florida DAV from South Alabama." That is the way I am normally introduced and, you know, they say that everybody loves us, now this is great, but you can be loved to death. We need hospitals where they will do the most good, not where they are 50 miles from another hospital.
Thank you.
Mr. SHELBY. We share your concern and that is why we are here.
Has anybody else additional testimony?

STATEMENT OF DAVID CARTER

Mr. CARTER. Congressman Shelby, Congressman Dowdy, and Congressman Callahan, I am David Carter. I have been executive direc-

tor for northwest Florida and Big Ben Health Planning Council for the last 2 years. Prior to that, I was executive director of the Areawide Health Planning Agency in Montgomery, Ala., for 14 years. I am a graduate of Auburn University and the University of Alabama Health Services Administration Program; therefore, I feel I know both Alabama and northwest Florida.

I have also participated in regular meetings of the VA District 10 MEDIPP Community Advisory Group and the purpose of my testimony is to strongly support the 1983 and 1984 Medical District 10 Plan for a VA Hospital in the Florida Panhandle.

The planning process, including the hard data, the perceived needs of the veterans' community and the technical expertise of professionals were all given exhaustive evaluation in the development of this plan.

In my opinion it is one of the best jobs of planning I have witnessed in my 16 years as Director of an areawide planning agency. According to the data book, and the Office of Information Management and Statistics of the VA, the three counties of southwest Alabama, including Mobile, are projected to decrease in the veterans' population by 5 percent in the next 15 years. The veterans' population of the seven southern Mississippi counties around Biloxi are projected to decrease 6.8 percent. On the other hand, the veterans' population of the 12 counties of the Panhandle of Florida west to the Appalachicola River is projected to increase by 18 percent during the same period.

Actual projections based on the 1980 census are as follows:

South Alabama in 1982 had 55,000 veterans. By the year 2000, only 53,000 veterans.

South Mississippi in 1982, 47,000 veterans. By the year 2000, only 44,000 veterans.

The Florida Panhandle, the 12 counties, in 1982 had 93,000 veterans. By the year 2000, they will have 110,000 veterans.

You may ask why there is a projected decrease of veterans for south Alabama and Mississippi when the population is slowly increasing?

The answer is simple. From a demographic standpoint, the greatest death rate among males age 65 and older will be in the large surge of World War II veterans and, therefore, a slow increase in the general population as is projected with the Tennessee-Tombigbee Waterway Development will be offset by the higher death rate among older male veterans.

The overall population projection for the Florida Panhandle indicates a significant growth rate for that area, which will override the higher death rate for World War II aged male veterans.

If you have tried to drive along the panhandle coastline recently, as we did this morning, you know the population explosion that is taking place there.

These are projections that I deal with in my office on a daily basis. It is easy to verify their accuracy, both on a professional and a personal basis. A VA hospital placed in Mobile, just 64 miles from Biloxi, would leave only 44,000 veterans to be served by that facility, thus devastating an excellent program developed there through the years which is currently experiencing an $80 million expansion and renovation.

A VA hospital in the Florida Panhandle would serve approximately 110,000 veterans and this would allow the approximately 100,000 veterans from south Alabama and Mississippi to be served by the newly refurbished Biloxi facility.

I have heard some say that the VA will build only tertiary and affiliated hospitals, but that simply is not so since the facility recently approved in Palm Beach and Brevard Counties are primary secondary hospitals.

It has been said that panhandle veterans could better be served by a hospital in Mobile. Well, I am here to tell you this morning—this afternoon it is now—it is 175 miles from my front door to the closest VA hospital and that is Montgomery, AL, but it is 181 miles from my front door to Providence Hospital in Mobile, AL. That kind of service the veterans of the panhandle don't need any more of.

It has been said that there are insufficient nurses and physicians in the Florida Panhandle to staff a VA hospital, but I can certify to the fact that there is a surplus of nurses in the Florida Panhandle today and we have been contacted by a number of nurses who would like very much to affiliate with a VA hospital in the panhandle.

We have three military hospitals in the panhandle that provide an excellent recruitment potential for a VA hospital medical staff.

For years we have heard that by 1990, there will be a surplus of physicians nationwide and we are already seeing a great deal of competition for patients among them in our area.

It is my understanding that the VA is looking at the needs of the 1990's and beyond, not the unmet needs for professionals in the past.

Thank you very much for the opportunity of speaking before you here today. I have a written statement.

Mr. SHELBY. It is submitted for the record without objection.

Mr. CARTER. If you have any questions, I will be glad to try to answer them.

[The statement of Mr. Carter appears on p. 273.]

Mr. SHELBY. Mr. Hixson, if you will, please briefly sum up anything that hasn't been said.

STATEMENT OF JIM HIXSON

Mr. HIXSON. Thank you, sir.

Sir, I am Jim Hixson with the Veterans' Service Office in Bay County Florida. We are discussing the problems that our veterans have in transport to and from the facility. The closest VA medical facility is 170 miles for any of our people. If I go south, it is 250 miles. If I go east, it is 190 miles.

As has been said, this kind of traffic and this kind of mileage is not what the veteran needs. We lose veterans every day because they can't make it to VA medical facilities.

The local facilities are expensive. The veteran generally is on social security. A World War II veteran, or a Korean war veteran who is handicapped or unable to work and requires medical assistance, then the VA is the only place that they can get it. They cannot afford it locally.

This type traveling and being turned away when they get there for whatever reason, that is not providing medical care for the veterans, and that is what is needed. Thank you.

Mr. SHELBY. Thank you. I appreciate your coming over and waiting.

Thank you. This will conclude our hearing.

[Whereupon, at 12:40 p.m., the subcommittee was adjourned.]

APPENDIX

DEMOCRATS
G. V. (SONNY) MONTGOMERY, MISS.
DON EDWARDS, CALIF.
TED STUDDS, MASS.
SAM B. HALL, JR., TEX.
DOUGLAS APPLEGATE, OHIO
MARVIN LEATH, TEX.
RICHARD C. SHELBY, ALA.
DAN MICA, FLA.
THOMAS A. DASCHLE, S. DAK.
WAYNE DOWDY, MISS.
MATTHEW G. MARTINEZ, CALIF.
LANE EVANS, ILL.
MARCY KAPTUR, OHIO
FRANK HARRISON, PA.
ALAN B. MOLLOHAN, W. VA.
TIMOTHY J. PENNY, MINN.
HARLEY O. STAGGERS, JR., W. VA.
J. ROY ROWLAND, GA.
JIM SLATTERY, KANS.
JOHN BRYANT, TEX.
JAMES J. FLORIO, N.J.
MACK FLEMING
CHIEF COUNSEL AND STAFF DIRECTOR

NINETY-EIGHTH CONGRESS
G. V. (SONNY) MONTGOMERY
CHAIRMAN

U.S. House of Representatives
COMMITTEE ON VETERANS' AFFAIRS
335 CANNON HOUSE OFFICE BUILDING
Washington, D.C. 20515

REPUBLICANS
JOHN PAUL HAMMERSCHMIDT, ARK.
CHALMERS P. WYLIE, OHIO
ELWOOD HILLIS, IND.
GERALD B. H. SOLOMON, N.Y.
BOB MATHEWS, OHIO
CHRISTOPHER H. SMITH, N.J.
DENNY SMITH, OREG.
PHIL GRAMM, TEX.
DAN BURTON, IND.
DON SUNDQUIST, TENN.
MICHAEL BILIRAKIS, FLA.
NANCY LEE JOHNSON, CONN.

DATE: June 28, 1984

TO: Chairman Montgomery

FROM: Ralph Casteel

SUBJECT: Providence Hospital, Mobile, Alabama

At your request Mack Fleming and I met with Congressman Jack Edwards on March 27, 1984, to discuss the proposal that the Veterans Administration purchase the Providence Hospital in Mobile, Alabama, for the purpose of operating it as a VA Medical Center. Mr. Edwards briefed us on the background of this proposal and furnished us with pertinent materials on the hospital and the community. He requested that a member of the staff visit Mobile at the earliest possible date to review this proposal with those concerned in the community.

The site visit was accomplished on April 2-3, 1984. The "prime movers" for the acquisition of this property by the VA are the service organizations in the area. Through their efforts, the entire community strongly supports the proposal. In addition, it is also favored by the University of South Alabama and its School of Medicine. In this regard, I talked by telephone with Dr. Stanley E. Crawford, Dean, University of South Alabama School of Medicine. He expressed strong support for the presence of a VA Medical Center in Mobile and the affiliation of such an institution with the School of Medicine.

The Committee's files on this subject include a list of all of the individuals who play a key role in Mobile in the attempt to sell this property to the VA or other purchasers.

The Providence Hospital is operated under the auspices of the Daughters of Charity of Saint Vincent DePaul and consists of 349 acute care beds, a 34-station renal dialysis unit, a 120-bed school of nursing. It is located on approximately 15.3 acres with 1,000 paved parking spaces. In addition, there is a residence on the hospital grounds with space to house 13 employees. This residence (including a 3-car garage) is included in the parcel of land.

The VA had an eight-member team visit this site March 26-28, 1984. The report of their visit (available in the Committee files) was furnished to the Committee by a June 1, 1984 letter from the Administrator. This letter appended reports requested by Committee staff, including the "Florida Panhandle Workbook" prepared by Medical District 10 and "Report on the Potential Size and Impact of the VA Medical Center in Mobile, Alabama." The transmittal indicates that the entire package of information is being furnished Medical District 10 for analysis and formulation of programmatic plans as part of the Medical District Initiated Program Planning (MEDIPP) process.

The VA site visit team report concludes that the Providence Hospital is "well maintained and in generally good condition. The newest construction is in excellent condition." Further, it states that if a VA Medical Center were established, certain modifications would be required, and a cost estimate on such modifications cannot be made in the absence of specific service levels and space programs. It ends with the conclusion that if a programmatic determination were made to establish a VA Medical Center in Mobile, the Providence Hospital could be adapted to serve in this role. (emphasis added)

The Florida Panhandle Workbook prepared by Medical District 10 (the Medical District consisting of the States of Alabama, Mississippi, and the Florida Panhandle) basically concludes the need for a general medical and surgical hospital in the Florida Panhandle in addition to the large outpatient clinic to be established in Pensacola, Florida. The bed-sizing and location (in order of preference) recommended by this study is as follows:

LOCATION	MED.	INTER.*	SURG.	NP	TOTAL BEDS
Fort Walton Beach	120	60	30	15	225
Panama City	150	60	30	15	255
Pensacola	120	60	30	15	225

* Intermediate medical

While the study does not recommend a specific date for constructing these beds, the implication is they will be required by 1990 or as soon thereafter as possible. No costs are projected for the construction of a new VA Medical Center in the Florida Panhandle. However, VA officials have stated verbally that it would be reasonable to use a construction cost of $300,000 per bed or $67.5 million for a 225-bed hospital in the Florida Panhandle. It is unclear whether this figure would include site acquisition, A/E costs, and site preparation. Further, this is based on current costs and does not allow for increases in the future. It is my opinion that a 225-bed hospital, the construction of which would not begin until 1990 or thereafter, would cost the VA $90 to $100 million at a minimum.

Last, at our request, the VA prepared a report on the "Potential Size and Impact of a VA Medical Center in Mobile, Alabama." The three pertinent conclusions of this study are quoted as follows:

"1. The number of beds allocated to VAMC Biloxi would have to be reduced and the ongoing multi-million dollar construction project might have to be downsized to accommodate the bed reduction.

2. The number of beds allocated to VAMC Montgomery would have to be slightly reduced.

3. The number of beds allocated to the proposed new VAMC in the Florida Panhandle would have to be reduced, which could make it's establishment questionable. This is contrary to the Congressionally mandated study on the need for additional hospital beds in Florida." (emphasis added)

After my site visit to the Providence Hospital, a subsequent meeting with the VA team that visited Mobile, a meeting with the Director of Program Analysis and Development of the Department of Medicine and Surgery (Dr. Murray Mitts), and a thorough review of the materials submitted by the Administrator of Veterans' Affairs, my observations are:

1. The Providence Hospital, Mobile, Alabama, is a well equipped and excellently maintained tertiary care hospital.

2. The appraised value of the property (less medical equipment) is $24 million. The appraisal was accomplished by the firm Courtney and Morris Appraisals, Inc. of Mobile. This firm is a member of the American Institute of Real Estate Appraisers, and the Society of Real Estate Appraisers value would appear to be a very fair market price for this property.

3. Most, if not all, of the medical equipment in the Providence Hospital could be purchased by a buyer through negotiations. This would include such items as the computer system, CAT Scanner, and sophisticated clinical laboratory equipment. In my opinion, it could be obtained at a most favorable price.

4. It has been consistently emphasized by the Committee staff that the need for a VA Medical Center in this area must be determined by the VA. Should such a need be determined to exist in Southern Alabama or the Panhandle of Florida, it would be both prudent and economically essential that serious consideration be given to acquiring this property. VA's per-bed cost estimate for construction would put new construction at an estimated $67.5 million for a 225-bed facility. This 349-bed facility, including any necessary modifications, in my opinion, would cost much less.

5. The location of the University of South Alabama School of Medicine practically adjacent to the Providence Hospital greatly enhances the proper staffing of a VA Medical Center at this location as opposed to the communities of Fort Walton Beach, Panama City, and Pensacola, Florida.

6. The heaviest concentration of veterans in the area discussed is in Mobile County, Alabama. This is followed by the three most westerly counties of the Florida Panhandle (Escambia, Santa Rosa, and Okaloosa) all of which are located within a reasonable commuting distance of Mobile.

In light of the above, I believe this matter should be further pursued with the Administrator of Veterans' Affairs and my recommendations are that:

1. Should the VA determine there is a need for a VA Medical Center to serve veterans in the Panhandle of Florida and Southern Alabama, the Administrator be urged to give serious consideration to the acquisition of Providence Hospital, Mobile, Alabama.

2. Should the VA determine that a new VA Medical Center is to be constructed in the Panhandle of Florida as recommended by the Florida Panhandle Workbook, the Agency be required to show that the Providence Hospital would not be suitable to meet the needs of veterans in South Alabama and the Panhandle of Florida and that it would not be economically feasible to purchase this property versus new construction. This can be accomplished under the authorization process required by section 5004, chapter 81, title 38, U.S.C.

3. Should the VA opt for new construction in either of the three locations mentioned in the Florida Panhandle Workbook (Fort Walton Beach, Panama City, and Pensacola) the Agency be required to show that staffing of such facility will be accomplished without undue difficulty and that the quality of care to be provided will be comparable to or exceed that which is provided in the community of Mobile with a close affiliation with the University of South Alabama School of Medicine.

FINAL REPORT ON FUTURE BED NEED AND POTENTIAL SITES FOR NEW VA HOSPITALS IN FLORIDA

Veterans Administration

Executive Summary

TABLE OF CONTENTS

	Page
Executive Summary	i
I. Introduction	1
II. Suppressed Veteran Demand in Medical District 12	5
III. Total Medical District 12 and Florida Panhandle Bed Need	7
IV. Access Discrepancies in Medical District 12 and the Florida Panhandle	11
V. Analysis of Potential Sites for New Hospitals	13
VI. Projection of Beds at Feasible Sites	23
VII. Summary of Recommendations	25
Appendix 1	27
Appendix 2	55

A REPORT ON FUTURE BED NEED AND POTENTIAL SITES FOR NEW VA HOSPITALS IN FLORIDA

EXECUTIVE SUMMARY

A Thirty Year Study of the Needs of Veterans in Florida, completed in December 1982, documented the need for 1,251 additional VA hospital beds in Florida to meet veteran population demand by a 1995 planning horizon. The following study, A Report on Future Bed Need and Potential Sites for New VA Hospitals in Florida, reassesses hospital bed need by 1995 and examines potential sites for new VA hospitals in Florida.

The State of Florida includes parts of two VA medical districts. Medical District 10 covers eight counties in the panhandle area of Florida, while Medical District 12 covers the rest of Florida, and an additional 19 counties in Georgia. Like the Thirty Year Study, this Report includes all of Medical District 12 as well as the Florida counties in Medical District 10. This Report was conducted through the Medical District Initiated Program Planning (MEDIPP) process in Medical District 12, with participation by Medical District 10.

The Thirty Year Study projects hospital bed need by applying the VA/GAO bed sizing model to existing VA hospitals in Florida. In so doing, future hospital bed need is based on historic use rates of VA hospitals in Florida, and these rates are multiplied by the projected Florida veteran population. A major shortcoming of this approach is that projections based on historic utilization understate future bed need if, historically, reasonable patient access to care has been limited by the number and/or location of available beds. The Thirty Year Study addressed this flaw in the methodology by noting that the hospital bed projections contained therein "are conservative because of the constrained demand in Florida."

The analysis summarized in this Report began with an examination of this phenomenon of constrained or "suppressed" demand in Florida relative to other VA medical districts as well as to the nation as a whole. The results show that Florida ranks among the top four of all VA medical districts and exceeds the VA national average on each of five predetermined indicators of suppressed demand.

This documentation prompted the development of a different aproach to determining total VA hospital bed need in Florida. Specifically, the VA/GAO bed sizing model was applied to the VA hospitals in the nation. The resulting national age-specific use rates were then multiplied by the projected age-specific Florida veteran population to determine the total bed need addressed in this Report. The basis for this method is the 1982 Medical District 12 Plan which was the foundation upon which the Thirty Year Study was developed. A stated goal in the 1982 Plan specifies that the supply of inpatient and outpatient services in Florida should be comparable to national levels of availability.

Applied to the nation's VA hospitals, the VA/GAO bed sizing model corrects for the phenomena of (a) excess hospital capacity, (b) inappropriate hospital utilization, and (c) excessive lengths of stay in acute beds. The national number of hospital beds upon which the hospital use rates applied to the Florida population are based is conservative.

This method documents the need for 1,429 additional hospital beds in Florida by 1990 and 2,121 additional beds by 1995. Since 242 of these beds have previously been sited for extended psychiatry at existing VA medical centers in Florida, the net additional hospital bed need is 1,187 by 1990 and 1,879 by 1995.

The process of determining sites for additional hospital beds began with an analysis of veteran access to existing VA hospitals. Data were gathered and analyzed on four predetermined indicators of access discrepancy and on the current distribution of VA hospital beds in Florida. This analysis documents that utilization of VA hospital care by Florida veterans decreases significantly as distance from the nearest VA hospital increases; in addition, access to VA hospital care appears to be limited in south Florida due to less availability of beds per veteran population in that area.

The Thirty Year Study recommends that additional beds "be located in areas having the greatest veteran demand and the least access to VA services." This philosophy was formally adopted as a planning policy in Medical District 12 and guided the development of criteria and standards for the selection of feasible sites for new VA hospitals in Florida.

First, criteria involving distance and population factors were developed in order to objectively select potential sites for new hospitals. These criteria were applied to each county in Florida and the 19 Georgia counties of Medical District 12, resulting in 13 potential sites. Next, standards were applied to each potential site to determine those which would be feasible sites for new VA hospitals. Specifically, for each potential site, a theoretical primary service area (PSA) was outlined to include those counties which are closer to the potential site than to existing VA hospitals. Comprehensive analyses of the size of the projected 1995 veteran population in each theoretical PSA from the nearest existing VA hospital were conducted. The potential impact of each potential hospital on existing hospitals as well as other potential hospitals was also considered.

Following the selection of feasible sites, the appropriate number of hospital beds was projected for 1995 at each feasible site, based on adopted methods and standards as well as the professional judgement of the Medical District Planning Board. Since this Report is limited to siting beds at new hospitals, and does not include allocation of additional beds to existing facilities, not all of the 1,879 additional beds projected by 1995 were sited. The projections of beds needed at new sites were not specifically influenced by overall Florida bed need; rather, beds were projected at new feasible sites based on the projected needs of the veteran populations within the theoretical PSAs of each of the feasible sites.

Following are the feasible sites for new hospitals, in priority order, and the number of hospital beds projected for 1995 at each site:

Proposed New VA Hospital Site	Beds
Palm Beach County	625
Brevard County	470
Florida Panhandle (Medical District 10)	215
Lee County	215
TOTAL	1,525

Where applicable, VA-DoD sharing should be evaluated in lieu of new hospital construction. The greatest DoD hospital capacity exists in the Florida Panhandle area of Medical District 10.

Further analysis of the specific siting of a hospital in the Florida Panhandle area of Medical District 10 as well as evaluation of VA-DoD sharing in lieu of construction of a new hospital in this area will be conducted by Medical District 10, with participation by Medical District 12 in its planning process. Potential sites under consideration include Bay, Escambia, and Okaloosa Counties. Recommendations on this issue will be made later this year.

The total number of projected hospital beds at new feasible sites (1,525) accounts for 81 percent of the additional beds justified by 1995 (1,879). This leaves a maximum of 354 beds which may be allocated to the five existing hospitals depending upon documented future need at each of these facilities. The potential for activating additional beds without new construction does exist at some of these hospitals. Allocation of beds at existing hospitals will be studied further and addressed in the Medical District Plan to be submitted in November of this year.

I. INTRODUCTION

For the past two years, the Veterans Administration (VA) Department of Medicine & Surgery has been involved in the Medical District Initiated Program Planning (MEDIPP) effort. MEDIPP is a decentralized population-based planning process which involves medical districts in planning for the utilization of available resources based on the health care needs of an estimated number of eligible veterans.

The first Medical District Plans were developed from November 1981 through November 1982. During the same time period, Florida was developing A Thirty Year Study of the Needs of Veterans in Florida in response to a Congressional directive accompanying Public Law 97-101, enacted December 23, 1981. In order to be consistent with MEDIPP's 1990 planning horizon, the Thirty Year Study was presented in ten-year intervals of 1990, 2000, and 2010.

The state of Florida includes portions of two VA medical districts. Medical District 10 includes eight counties in the Panhandle area of the state, while Medical District 12 covers the rest of Florida and 19 counties in Georgia. The Thirty-Year Study includes all of Medical District 12 as well as the Florida counties of Medical District 10 and used the two District Plans as the basis for the Study.

While the District Plans and the Thirty Year Study address a variety of health care service and facility needs, this special report is limited to projecting hospital bed need and examining the feasibility of potential sites for new VA hospitals in Florida. Currently, all five existing hospitals are located in the Medical District 12 portion of Florida; no hospitals are located in the eight Florida Panhandle counties of Medical District 10 or the 19 Georgia counties of Medical District 12.

Florida is one of only two areas in the nation where veteran population is projected to increase in future years, while veteran population is decreasing in the nation as a whole. However, due to the increasing age of Florida veterans, the population is projected to decline significantly by the year 2010, after peaking about the year 2000.

These population dynamics affect planning for hospitals, nursing homes and outpatient clinics in that care must be taken not to create expensive facilities which may not be needed in future years. For this reason, the District Plan and the Thirty Year Study promote the development of non-institutional innovations, such as adult day care centers, hospital-based home care, and residential care, to offset some of the inpatient bed needs. However, plans are also included to meet the inpatient needs of a growing veteran population over the next 20 years. The Medical District Plan projects the need for 726 additional hospital beds in Medical District 12 by 1990. The Thirty Year Study adds the Panhandle counties and projects the need for 1,019, 1,483, and 219 additional hospital beds by 1990, 2000 and 2010, respectively.

These projected hospital beds are based on a computer model, the VA/GAO bed sizing model, which assumes that the historic rates of hospital use will continue in the future. Thus, the farther into the future that the model projects, the less accurate are the resulting numbers. Therefore, for purposes of developing cost estimates, the Thirty Year Study addresses 1,251 beds (the mean number of projected beds between the years 1990 and 2000) for a 1995 planning horizon. This was based on a premise stated in the study:

> Although medical care needs peak in 2000, plann'ng needs should be based on needs between 1990 and 2000 in order to minimize excess capacity in non-peak years.

Of the projected additional hospital beds, a total of 242 extended psychiatry beds were recommended for placement at the Gainesville and Miami VA Medical Centers.

Site selection for approximately 1,000 additional projected hospital beds was delayed for further study of veteran population to assure location in areas having the greatest veteran populations with the least access to current VA services. Additionally, the Medical District 12 Planning Board viewed the output of the computer model for Medical District 12 hospitals as only the first step in the assessment of bed need. The Board expressed its intention to use the current planning cycle to document suppressed demand in Florida due to a veteran population which is continuing to increase much faster than VA resources to the State.

The process used to develop this report involved adoption by the Medical District Planning Board of principles, methods, and standards for projecting and allocating hospital bed need based on goals in the District Plan. A subgroup of the Board was then appointed to analyze related data, project bed need by bed section, develop theoretical primary service areas, and make recommendations to the Board regarding bed need and potential sites. The Subgroup included one member from each medical center and consisted of a Chief of Staff, an Associate Director, and a physician from each of the major services.

Medical District 10 participated in the development and review of data as well as Planning Board recommendations that could affect that District's plans. Input was also received from the VA medical center planning committees, the Veterans Review Group for Medical District Planning, the District Professional Council, the District Administrative Council and the District Executive Council. The recommendations contained in this report are based on logical principles and sound data positively supported by all those involved in the planning effort.

The remainder of this report includes the following sections:

II. Suppressed Veteran Demand in Medical District 12

The inadequacy of applying the VA/GAO bed sizing model to Florida hospitals in order to project future need for beds in Medical District 12 is documented in this section. Due to suppressed demand in Florida, projections based on past utilization of Florida VA hospitals understate the hospital needs of Florida veterans.

III. Total Medical District 12 and Florida Panhandle Bed Need

This section presents and applies a method for determining total VA hospital bed need by section for Medical District 12 and the Florida Panhandle. This method employs the VA/GAO bed sizing model in a manner which is consistent with District planning policies and which addresses the problem of suppressed demand relative to the nation as a whole.

IV. Access Discrepancies in Medical District 12 and the Florida Panhandle

Prior to allocating projected beds, the District Planning Board analyzed access discrepancies in Medical District 12 and the Florida Panhandle. This section documents areas which have restricted access to VA hospital care.

V. Analysis of Potential Sites for New Hospitals

The Medical District Director charged the District Planning Board with developing a list of potential sites and categorizing these sites as "feasible", "feasible with shortcomings", and "unfeasible". The analysis of these sites was based on Board-adopted policies and standards; the results of this analysis are included in this section.

VI. Projection of Beds at Feasible Sites

The Medical District Director also charged the District Planning Board with determining the appropriate number of beds at each feasible site. These decisions, which were based on Board-adopted policies, methods, and standards, are included in this section.

VII. Summary of Recommendations

A summary of all recommendations in this report is presented in this section.

II. SUPPRESSED VETERAN DEMAND IN MEDICAL DISTRICT 12

The VA/GAO bed sizing model projects future bed need in Medical District 12 based on actual historic utilization (1977-1980) of VA hospitals in the District. However, projections based on historic utilization understate future bed need if, historically, reasonable patient access has been restricted by the number and/or location of available beds. The following assumption was formally adopted by the District Planning Board in February 1983:

> THERE IS "SUPPRESSED DEMAND" IN MEDICAL DISTRICT 12 DUE TO THE NONAVAILABILITY OF SUFFICIENT RESOURCES.

As it relates to hospital beds, this assumption suggests that the bed sizing model would have projected need for a greater number of beds in 1990 had additional beds been available in Medical District 12.

The Planning Board chose certain indicators to test the assumption that there is suppressed demand for hospital care in Medical District 12 relative to other medical districts nationwide. These indicators were:

a) VA beneficiary (VAB) admissions/veteran population;
b) authorized beds/veteran population;
c) authorized beds/outpatient (fee and staff) visits;
d) authorized beds/applications for medical care; and,
e) percentage of inpatients who are service-connected.

Data were then gathered for each of these indicators. Table 1 shows that Medical District 12 ranks among the top four of all 28 districts and exceeds the VA national average on each of these indicators of suppressed demand.

TABLE 1
INDICATORS OF SUPPRESSED DEMAND

Indicator	MD12 Rate	District Rank	National Rate	National Range
VAB Adm./1000 Vets	2.1	3rd	1.0	.2 - 4.8
Beds/1000 Vets	2.1	3rd	2.8	1.6 - 4.7
Beds/1000 Visits	3.1	3rd	4.8	2.8 - 8.6
Beds/1000 Applications	19.1	3rd	30.4	16.8 - 65.5
% SC Inpatients	35.9	4th	31.8	14.8 - 41.8

The VAB admission rate in Medical District 12 and the percentage of inpatients in Medical District 12 who are service-connected are considerably above the national average; the numbers of Medical District 12 beds per thousand veteran population, beds per thousand outpatient visits, and beds per thousand applicants for medical care are considerably below the national average.

These indicators of suppressed demand provided a rationale for using a method other than application of the VA bed sizing model to the VA hospitals in Medical District 12.

III. TOTAL MEDICAL DISTRICT 12 AND FLORIDA PANHANDLE BED NEED

The following policy was formally adopted by the District Planning Board in February, 1983:

THE SUPPLY OF INPATIENT AND OUTPATIENT SERVICES SHOULD BE COMPARABLE TO NATIONAL LEVELS OF AVAILABILITY.

This policy was excerpted from a goal in the Medical District Plan submitted in November, 1982. Based on this policy, the Board adopted the following method for determining District 12 and Florida Panhandle bed need:

Calculate national age-specific bed ratios (beds per 1000 population) by section based on the 1990 outputs of the VA/GAO bed sizing model and apply these to the projected age-specific veteran population of Medical District 12 and the Florida Panhandle.

This method also addresses the problem of suppressed demand in Medical District 12 and the Panhandle relative to the nation as a whole.

Table 1 shows national age-specific bed ratios by section derived from the VA/GAO bed sizing model. Table 2 is the result of the application of these ratios to the projected 1990 and 1995 populations of Medical District 12 and the Florida Panhandle. It should be noted that "medicine" beds include internal medicine, rehabilitation and neurology beds. Also, spinal cord injury, blind rehabilitation and dialysis beds are not included in the projections.

7

47-660 O—85——3

TABLE 1
NATIONAL AGE-SPECIFIC BED RATIOS (BEDS PER 1000 VETERANS)
DERIVED FROM THE VA/GAO BED SIZING MODEL

Age	Medicine	Intermediate	Surgery	Psychiatry Acute	Psychiatry Extended
All	.81	.22	.44	.36	.25
0-24	.09	.03	.15	.41	.10
25-44	.10	.03	.10	.34	.10
45-54	.36	.11	.22	.28	.16
55-64	.75	.22	.44	.27	.25
65 +	2.15	.53	1.02	.52	.50

Sources: VA/GAO Bed Sizing Projections for 1984 Budget using 1981 MLC Survey Results, May, 1982.

TABLE 2
PROJECTED MD12/PANHANDLE BED NEED BY SECTION APPLYING NATIONAL
AGE-SPECIFIC BED RATIOS DERIVED FROM THE VA/GAO BED SIZING MODEL

	Authorized (1981)	Projected 1990	Difference From 1981	Projected 1995	Difference From 1981
Medicine	1239	1816	577	2143	904
Intermediate	211	468	147	547	336
Surgery	929	925	4	1074	145
Psychiatry	537	1136	599	1273	736
Acute	537	639	102	704	167
Extended	0	497	497	569	569
TOTAL	2916	4345	1429	5037	2121

Sources: VA/GAO Bed Sizing Projections for 1984 Budget using 1981 MLC Survey Results, May, 1982; Applied Population Laboratory, University of Wisconsin (March, 1983)

Thus, this method documents the need for 1,429 additional hospital beds in Florida by 1990 and 2,121 additional beds by 1995. Since 242 of these beds have previously been sited for extended psychiatry at existing VA medical centers in Florida, the net additional hospital bed need is 1,187 by 1990 and 1,879 by 1995.

Using this method, the total projected bed need in Medical District 12 and the Florida Panhandle exceeds the number of beds projected in the Thirty Year Study. The District Planning Board, however, strongly believes that the number of beds projected by this method more nearly approximates the need for increased VA hospital services in Florida. This belief is supported by disclaimers stated in the Thirty Year Study:

> To the extent that the trend of the historical utilization does not continue, projections will be inaccurate...These estimates in general are conservative because of the constrained demand in Florida (A Thirty Year Study of the Needs of Veterans in Florida, page 10).

9

IV. ACCESS DISCREPANCIES IN MEDICAL DISTRICT 12 AND THE FLORIDA PANHANDLE

Due to the number and location of existing VA hospital beds within Florida, reasonable access to care is thought to be especially restricted in certain areas of the State. The District Planning Board selected several indicators to test the assumptions of access discrepancies within Medical District 12 and the Florida Panhandle. These included:

a) number and rate of VAB applications by county;
b) number and rate of fee basis visits by county;
c) VA discharge rates by county and service area; and,
d) beds per veteran population in the northern, central, and southern service areas.

Higher county rates for VAB applications and fee basis visits, and lower county rates for VA discharges, were all highly correlated with distance from the nearest existing VA hospital.

The availability of beds per veteran population in service areas of existing VA hospitals was a factor also considered. Table 4 shows significantly fewer beds and lower utilization per veteran population in south Florida in 1982 than in other areas of Medical District 12.

TABLE 4

NORTHERN AREA (Gainesville/Lake City PSA)

Veteran Population	Authorized Beds	Beds/1000 Population	VA Discharges/1000 Population
283,221	838	3.0	56

CENTRAL AREA (Tampa/Bay Pines PSA)

Veteran Population	Authorized Beds	Beds/1000 Population	VA Discharges/1000 Population
584,713	1,360	2.3	42

SOUTHERN AREA (Miami PSA)

Veteran Population	Authorized Beds	Beds/1000 Population	VA Discharges/1000 Population
541,830	831	1.5	26

Thus, based on these access indicators, utilization of VA hospital resources decreases as distance from the nearest VA hospital increases; also, VA hospital utilization is less in the southern part of the state.

V. ANALYSIS OF POTENTIAL SITES FOR NEW HOSPITALS

The following policy was formally adopted by the District Planning Board in February 1983:

> NEW CONSTRUCTION OF HOSPITAL BEDS SHOULD BE IN AN AREA WHICH WOULD IMPROVE ACCESSIBILITY TO INPATIENT CARE FOR THE GREATEST NUMBER OF VETERANS.

This policy is consistent with adopted principles in the Medical District Plan submitted in November 1982. Based on this policy, the Board adopted criteria for selecting potential sites for new VA hospitals and standards for selecting those potential sites which would be feasible sites for new hospitals.

The following criteria were used to select potential sites for new VA hospitals in Florida:

a. Only those counties with a minimum veteran population of 10,000 which are also part of a metropolitan statistical area (MSA) should be considered.

b. Only those counties that are at least 50 miles from an existing VA medical center should be considered, except for counties with a high density veteran population bordering on a potential site.

Following are the 13 counties in Medical District 12 and the Florida Panhandle which met both of these criteria (MSAs are in parentheses):

1. a. Bay (Panama City)
   b. Escambia (Pensacola)
   c. Okaloosa (Fort Walton Beach)

2. a. Brevard (Melbourne-Titusville-Cocoa)
   b. Orange (Orlando)
   c. Seminole (Orlando)
   d. Volusia (Daytona Beach)

3. Duval (Jacksonville)

4. a. Lee (Fort Myers-Cape Coral)
   b. Sarasota (Sarasota)

5. Leon (Tallahassee)

6. a. Palm Beach (West Palm-Boca Raton)
   b. Broward (Fort Lauderdale-Hollywood)

As shown, the potential sites are organized into six groups. Because of the proximity of each county in a single group to one another, it was presumed that selection of one site in a group would rule out the selection of any other site in the same group. Map 1 displays the counties selected as potential sites.

Map 1
Potential Sites for Bed Allocation

Georgia
Alabama
Counties which:
a. are in an MSA;
b. have a minimum veteran population of 10,000 or more; and
c. are 50 miles or more from an existing VA medical center, except for counties with high density veteran population bordering on a potential siting.
Counties with existing VAMC's.

The following standards were applied to each of the 13 potential sites in order to select feasible sites for new hospitals:

1. Inpatient hospital services should be available within 50-75 miles of 80-90% of the District veteran population.

2. The PSA of a new hospital with primary and secondary services should include those counties which are closer to the proposed facility site than to existing VA hospitals.

3. The PSA of a new hospital should have a projected minimum veteran population of 150,000 by 1995.

The following addresses Standard 1:

a.	(80% of MD12/ Panhandle Vets)	-	(Vets Within 50 Miles of an Existing VAMC)	=	(Minimum Number of Vets to be Brought Within 50 Miles Access)
	(1,387,294)	-	(959,177)	=	(428,117)
b.	(80% of MD/12 Panhandle Vets)	-	(Vets Within 75 Miles of an Existing VAMC)	=	(Minimum Number of Vets to be Brought Within 75 Miles Access)
	(1,387,294)	-	(1,257,095)	=	(130,199)
c.	(90% of MD12/ Panhandle Vets)	-	(Vets Within 50 Miles of an Existing VAMC)	=	(Minimum Number of Vets to be Brought Within 50 Miles Access)
	(1,560,705)	-	(959,177)	=	(601,528)
d.	(90% of MD12/ Panhandle Vets)	-	(Vets Within 75 Miles of an Existing VAMC)	=	(Minimum Number of Vets to be Brought Within 75 Miles Access)
	(1,560,705)	-	(1,257,095)	=	(303,610)

Thus, for Standard 1 to be met, new hospitals should be located in areas which would 1) bring access to a hospital within 50 miles for at least 428,117 veterans who are over 50 miles from an existing hospital, and/or 2) bring access to a hospital within 75 miles for at least 130,199 veterans who are over 75 miles from an existing hospital.

Regarding Standards 2 and 3, Maps 1-13 and Tables 1-13 in Appendix 1 specify the theoretical primary service areas (PSAs) of each of the 13 potential sites. Following is an explanation of the table columns:

Column 1 — distance from the nearest hospital to the population center of the respective PSA county. Distances were provided by a VACO computer program and represent straight-line distance rather than road mileage.

Column 2 — distance from the population center of the potential hospital site to the population center of the respective PSA county.

Column 3 -- difference between Column 1 and Column 2. This indicates the potential improvement in access for individuals of each PSA county.

Column 4 -- projected 1995 veteran population in each PSA county according to the latest Voss figures (Applied Laboratory, University of Wisconsin-Madison, March 1983).

Column 5 -- Access Index. For each county, Column 3 is multiplied by Column 4 to measure the potential improvement in access for the veteran population in each PSA county. The sum of the county measures is the PSA Access Index. The higher the PSA Access Index, the greater is the potential improvement in access for the veteran population of the PSA.

Summary Table 5 (page 19) compares the 13 potential sites on each of the following indices:

1) 1995 total veteran population in the theoretical PSA;

2) 1995 veteran population which is over 50 miles from an existing VA hospital, but within 50 miles of the potential site;

3) 1995 veteran population which is over 75 miles from an existing VA hospital, but within 75 miles of the potential site.

4) distance from the population center of the potential site to the nearest existing hospital; and,

5) PSA Access Index, which combines distance and population factors to measure overall potential improvement in access.

A fourth standard was adopted concerning the impact of new hospital construction on existing hospitals:

4. New hospitals should be located at sites which would minimize the negative impact on the utilization of existing (or other planned) hospitals.

Tables 6 and 7 (pages 20-21) indicate the numbers of discharges to the theoretical PSAs from each existing hospital in Medical Districts 12 and 10, respectively. Also indicated is the distance of the potential hospital sites to each of the existing hospitals.

Selection of Feasible Sites

Following analysis of distance and population factors, as well as potential impact on existing facilities, "feasible" sites were determined for new hospitals:

1. Palm Beach County

2. Brevard County

3. One of the Florida Panhandle counties in Medical District 10. Utilization of available Department of Defense (DOD) beds in lieu of new hospital construction should be evaluated.

4. Lee County

Both Plam Beach and Brevard Counties (or, alternatively, other counties in their groups) are considered clearly superior to all other sites. These are the only sites which meet Standard 3 which recommends that theoretical PSA populations include at least 150,000 veterans by 1995. The following reasons make a strong argument for Palm Beach or Brevard Counties:

1) Utilization and bed availability per population are lower in the southern area of Medical District 12 (refer to Table 4, page 11).

2) Although Broward County (1995 veteran population: 209,510) is not in the Palm Beach theoretical PSA, a new hospital in Palm Beach County would attract about half of the Broward County veteran population.

3) Based on U.S. Census information, it does not appear that there is a significant difference between the Brevard and Palm Beach theoretical PSAs regarding the percent of population below the poverty level.

4) The population in the Palm Beach PSA (including Broward County) accounts for about 30 percent of the Miami VAMC workload and the Brevard PSA accounts for about 14 and 13 percent of the workload of Tampa and Gainesville VAMCs, respectively.

The Lee County theoretical PSA includes five counties which are also in the Palm Beach theoretical PSA, with a total 1995 population of 34,260 veterans. On the other hand, VA/DOD sharing should be considered in lieu of establishing a new hospital in the Panhandle. The Panhandle counties include the following DOD hospitals:

	County	Authorized Beds (1981)	Operating Beds (1981)	ADC (1981)
Eglin Air Force base	Okaloosa	200	145	111
Tyndall Air Force Base	Bay	80	35	28
Pensacola Naval Base	Escambia	310	115	94
TOTAL		590	295	233

It is also agreed that recommendations on the site of a new hospital in the Florida Panhandle counties of Medical District 10 will be made by Medical District 10, with participation by Medical District 12 in its planning process.

Lee County and the Medical District 10 Florida Panhandle counties are considered clearly superior as hospital sites to either Duval or Leon Counties in terms of access factors and relative impact on existing facilities. Duval County is categorized as "feasible with shortcomings". A hospital in Duval County (Jacksonville) could have a detrimental impact on Lake City and Gainesville hospitals, each of which are within 75 miles of Jacksonville. Both utilization and bed availability per veteran population in the northern area of Medical District 12 are considerably higher than in central and south Florida (refer to Table 4, page 11). In addition, the veteran population in central and south Florida will continue to increase faster than in north Florida.

VA/DOD sharing with the Jacksonville Naval Base should be considered:

	County	Authorized Beds (1981)	Operating Beds (1981)	ADC (1981)
Jacksonville Naval Base	Duval	376	177	147

Leon County is considered "unfeasible" since a hospital in the Florida Panhandle of Medical District 10 would consume a large portion of Leon's relatively sparsely populatd theoretical PSA. Similarly, given a hospital in Brevard County, Orange, Seminole and Volusia Counties are considered unfeasible due to their proximity to Brevard; Broward County is considered unfeasible given its proximity to Palm Beach County; Sarasota County is considered unfeasible given its proximity to Lee County; and, two of the three sites in the Panhandle would be unfeasible if a hospital is to be established at the other site.

TABLE 5
SUMMARY ANALYSIS OF POTENTIAL SITES

	1995 PSA Pop.	Rank	Pop. Brought Within 50 Miles	Rank	Pop. Brought Within 75 Miles	Rank	Distance from Nearest Hospital	Rank	Access Index	Rank
Bay (Panama City)	130,970	9	29,470	12	57,520	10	154	1	5,734	12
Escambia (Pensacola)	145,314	7	66,188	9	76,527	6	106	4	7,327	7
Okaloosa (Ft. Walton)	124,813	10	61,273	10	96,274	5	117	2	7,157	8
Brevard (Cocoa)	277,190	4	194,010	4	253,410	1	108	3	12,446	3
Orange (Orlando)	287,050	2	254,250	1	222,610	2	75	9	16,175	1
Seminole (Orlando)	287,050	2	254,250	1	222,610	2	84	7	15,886	2
Volusia (Daytona)	272,180	5	194,070	3	222,610	2	84	7	11,779	4
Duval (Jacksonville)	124,442	11	99,684	7	17,363	12	60	10	6,123	10
Lee (Ft. Myers)	121,990	12	83,300	8	65,770	7	100	5	6,742	9
Sarasota (Sarasota)	144,070	8	17,530	13	43,440	11	48	12	5,011	13
Leon (Tallahassee)	103,994	13	45,142	10	55,679	8	100	5	5,995	11
Palm Bch. (W. Palm)	158,940	6	124,680	5	48,270	9	59	11	9,133	5
Broward (Ft. Lauderdale)	368,450	1	110,670	6	16,720	13	23	13	7,967	6

TABLE 6

DISCHARGES AND DISTANCES FROM MD12 VAMC'S TO PROPOSED PSA'S AND PROPOSED HOSPITAL SITES

(Percent of Total Hospital Discharges in Parentheses)

	Lake City		Gainesville		Tampa		Bay Pines		Miami		Total
	Discharges to PSA	Distance from Proposed Site	Discharges to PSA	Distance from Proposed Site	Discharges to PSA	Distance from Proposed Site	Discharges to PSA	Distance from Proposed Site	Discharges to PSA	Distance from Proposed Site	Total Discharges to PSA
Bay (Panama City)	1141 (15.7)	179	641 (5.9)	200	42 (.3)	245	18 (.2)	245	0	441	1842
Escambia (Pensacola)	137 (1.2)	276	267 (2.4)	298	31 (.2)	335	14 (.1)	335	0	527	449
Okaloosa (Ft. Walton)	630 (8.6)	236	445 (4.1)	259	34 (.2)	306	17 (.2)	306	0	500	1126
Brevard (Cocoa)	44 (.6)	175	1454 (13.4)	138	1987 (14.3)	108	97 (1.0)	108	176 (1.3)	175	3758
Orange (Orlando)	55 (.7)	134	2233 (20.5)	96	2087 (15.0)	75	112 (1.1)	75	151 (1.1)	202	4638
Seminole (Orlando)	55 (.7)	128	2233 (20.5)	91	2087 (15.0)	84	112 (1.1)	84	151 (1.1)	202	4638
Volusia (Daytona)	60 (.8)	117	2292 (21.1)	84	2011 (14.5)	114	97 (1.0)	114	39 (.3)	235	4499
Duval (Jacksonville)	1707 (23.5)	60	1766 (16.3)	62	71 (.5)	168	14 (.1)	168	0	322	3558
Lee (Ft. Myers)	23 (.3)	249	53 (.5)	212	528 (3.8)	100	1079 (10.9)	100	240 (1.8)	114	1923
Sarasota (Sarasota)	16 (.2)	199	58 (.5)	165	878 (6.3)	48	2035 (20.6)	48	26 (.1)	171	3013
Leon (Tallahassee)	2218 (30.5)	100	1001 (9.2)	127	41 (.3)	203	19 (.1)	203	0	400	3272
Palm Bch. (W. Palm)	11 (.1)	286	45 (.4)	248	75 (.5)	168	45 (.4)	168	1239 (9.1)	59	1415
Broward (Ft. Lauderdale)	15 (.2)	316	52 (.5)	278	83 (.6)	188	59 (.8)	188	4009 (29.4)	23	4218

TABLE 7

DISCHARGES AND DISTANCES FROM MD10 VAMC'S TO PROPOSED PSA'S AND PROPOSED HOSPITAL SITES

(Percent of Total Hospital Discharges in Parentheses)

	Birmingham		Tuscaloosa		Montgomery		Tuskegee		Biloxi		Total
	Discharges to PSA	Distance from Proposed Site	Discharges to PSA	Distance from Proposed Site	Discharges to PSA	Distance from Proposed Site	Discharges to PSA	Distance from Proposed Site	Discharges to PSA	Distance from Proposed Site	Discharges to PSA
Bay (Panama City)	272 (3.1)	240	21 (.6)	237	309 (10.4)	154	593 (10.4)	154	494 (8.0)	203	1689
Escambia (Pensacola)	323 (3.7)	210	52 (1.6)	188	436 (14.7)	141	488 (8.5)	163	1674 (27.3)	106	2973
Leon (Tallahassee)	191 (2.2)	259	13 (.4)	271	219 (7.4)	177	612 (10.7)	160	45 (.7)	283	1080
Okaloosa (Ft. Walton)	456 (5.3)	201	45 (1.4)	188	559 (18.8)	122	759 (14.0)	136	693 (11.3)	147	2552

VI. PROJECTION OF BEDS AT FEASIBLE SITES

The appropriate number of hospital beds by section for the year 1995 was determined for each feasible site:

	Medicine	Intermediate	Surgery	Mixed MICU/SICU	Psychiatry	Total
Palm Beach	320	80	90	15	120	625
Brevard	240	40	60	10	120	470
Panhandle	120	—	30	5	60	215
Lee	120	—	30	5	60	215
TOTAL	800	120	210	35	360	1,525

Since this Report is limited to siting beds at new hospitals, and does not include allocation of additional beds to existing facilties, not all of the 1,879 additional beds projected by 1995 were sited. The projections of beds needed at new sites were not specifically influenced by overall Florida bed need; rather, beds were projected at new feasible sites based on the projected needs of the veteran populations within the theoretical PSAs of the feasible sites.

The following factors were used to determine the appropriate number of beds at each feasible site:

A. Age-specific bed ratios wer calculated by section based on he 1990 outputs of the VA/GAO bed sizing model for (a) the antion, (b) Lake City VAMC, and (c) Bay Pine VAMC. These ratios were than applied to the age-specific veteran population configurations of each of the theroetical PSAs.

Ratios for Lake City and Bay Pines were used because (1) these hospitals provide predominantly primary and secondary services and new hospitals would be limited to these services, (2) Lake City serves a large, sparsely populated PSA, whereas Bay Pines serves a smaller denseley populated PSA, and (3) Bay Pines has psychiatric and intermediate bed sections and Lake City does not.

B. The following Board-adopted standards were used as guidelines:

1. New VAMCs should have 300-500 beds (including hospital, NHCU, and domiciliary). However, additional NHCU or domiciliary beds may be added as long as total VAMC capacity does not exceed 550-575 beds (i.e., 10-15 percent in excess of the 500 bed limit.

2. No more than 240 nursing home beds should be located any any VAMC. (Plans to construct 120-bed NHCUs at the Orlando and Fort Myers satellite outpatient clinics should be shifted to new hospitals.)

3. Sharing arrangements with other federal and nonfederal health care providers will be maximized.

4. New construction of general acute care beds should involve primary and secondary services. (Official VACO definitions of "primary" and "secondary" services will be used.)

C. The professional judgement of the District Planning Board was also used. The Planning Board assumed general medicine (including intermediate) wards of 40 beds each, and surgical and psychiatric wards of 30 beds each. Also, each hospital was allocated a mixed MICU/SICU.

The Board made no distinction between acute and extended psychiatric beds. However, in projecting the total number of psychiatric beds, the Board considered the low number of psychiatric beds in Florida, increasing needs of the gero-psychiatric population, and the inclusion of alcohol treatment programs at each site.

The Board believes that the bed projections at feasible sites are conservative but that this is appropirate given projected decreases in demand after 2000. The total number of beds projected for Palm Beach takes into consideration that a hospital at this site would likely attract about half of the veteran population of Broward County. This number of beds (625) exceeds Standard 1 (page 23) which recommends a maximum of 500 hospital beds at new VA medical centers. However, this standard is mitigated by the size and density of the veteran population in that area of Florida.

It is also agreed that recommendations on the configuration of beds in the Florida Panhandle counties of Medical District 10 be made by Medical District 10, with participation by Medical District 12 in its planning process.

The total number of projected hopital beds at new feasible sites (1,525) accounts for 81 percent of the additional beds justified by 1995 (1,879). This leaves a maximum of 354 beds which may be allocated to the five existing hosptiels depending upon documented future need at each of these facilities. The potential for activating additional beds without new construction does exist at some of these hospitals. Allocation of beds at existing hospitals will be studied further and addressed in the Medical District Plan to be submitted in November of this year.

VII. SUMMARY OF RECOMMENDATIONS

The following is a summary of the major recommendations included in this Report.

A. The results of this study indicate that up to 2,121 additional VA hospital beds can be justified in Medical District 12 and the eight Florida Panhandle counties of Medical District 10 by 1995. Of these beds, 242 have previously been sited for extended psychiatry at Gainesville and Miami. The total number of beds at feasible sites accounts for 1,525 of the additional beds. This leaves a maximum of 354 beds which may be allocated to the five existing hospitals in Florida depending on documented future need at each of those facilities.

B. Based on Planning Board standards and criteria, there are four feasible sites for new hospitals in Medical District 12 and the Florida Panhandle. These sites are ranked in priority order with projected 1995 hospital beds at each site:

County/Area	Projected Beds
Palm Beach	625
Brevard	470
Florida Panhandle (Medical District 10)	215*
Lee	215*

Medical District 10 should make recommendations regarding the site and bed complement of a hospital in its eight Florida Panhandle counties, with participation by Medical District 12 in its planning process. The site should be one of the three urban counties (Bay, Escambia, or Okaloosa) identified in this Report. In any case, VA-DoD sharing should be evaluated in lieu of new hospital construction in the Panhandle.

Maps 1-4C in Appendix 2 address the implications of these recommendations for the primary service areas (PSAs) of existing and proposed hospitals in Florida. The PSAs were drawn according to Board-adopted standards.

Appendix I

Map 1
Bay County (Panama City MSA) and Theoretical PSA

Plus --

District 9 County:

Baker, GA

District 10 Counties:

Seminole, GA
Geneva, AL
Houston, AL

PSA Population

1990 - 124,990
1995 - 130,970
2000 - 133,230
2010 - 157,580

TABLE 1
BAY COUNTY PSA - Distance and Population Data

PSA Counties	1 Distance from Nearest Hospital (Miles)	2 Distance from Site	3 Difference (Column 1 - Column 2)	4 Veteran Population (1995)	5 Access Index (Column 3 X Column 4 ÷ 1000)
BAY	154/M	0	154	14,780	2,276
Calhoun	140/T	37	103	1,080	111
Escambia	106/B	98	8	32,630	261
Franklin	138/LC	53	85	1,120	95
Gadsden	123/LC	67	56	3,580	200
Gulf	158/LC	30	128	1,300	166
Holmes	107/M	47	60	2,140	128
Jackson	115/T	50	65	4,450	289
Leon	100/LC	83	17	23,850	405
Liberty	136/LC	46	90	520	47
Okaloosa	122/M	62	60	12,990	779
Santa Rosa	117/B	91	26	8,510	221
Wakulla	103/LC	77	26	1,790	47
Walton	113/M	47	66	3,340	220
Washington	118/T	36	82	1,860	153
Baker, GA	107/T	105	2	316	1
Decatur	124/LC	80	44	2,347	103
Grady	106/LC	97	9	1,931	17
Miller	104/T	86	18	563	10
Mitchell	115/LC	112	3	1,491	4
Seminole	110/T	73	37	830	31
Geneva, AL	91/M	63	28	2,582	72
Houston	86/T	72	14	6,970	98
TOTAL				130,970	5,734

M - Montgomery
T - Tuskegee
B - Biloxi
LC - Lake City

Map 2
Escambia County (Pensacola MSA) and Theoretical PSA

Plus --

District 10 Counties:

Baldwin, AL
Clarke, AL
Conecuh, AL
Covington, AL
Escambia, AL
Mobile, AL
Monroe, AL
Washington, AL

PSA Population

1990 - 141,344
1995 - 145,314
2000 - 146,734
2010 - 155,530

TABLE 2

ESCAMBIA COUNTY PSA - Distance and Population Data

PSA Counties	1 Distance from Nearest Hospital (Miles)	2 Distance from Site	3 Difference (Column 1 - Column 2)	4 Veteran Population (1995)	5 Access Index (Column 3 X Column 4 ÷ 1000)
ESCAMBIA	106/B	0	106	32,630	3,459
Bay	154/M	98	56	14,780	828
Calhoun	140/T	128	12	1,080	13
Gulf	158/LC	126	32	1,300	42
Holmes	107/M	92	15	2,140	32
Okaloosa	122/M	41	81	12,990	1,052
Santa Rosa	117/B	16	101	8,510	860
Walton	113/M	68	45	3,340	150
Washington	118/T	98	20	1,860	37
Baldwin, AL	77/B	32	45	7,696	346
Clarke	101/M	90	11	2,353	26
Conecuh	75/M	67	8	1,581	13
Covington	75/M	74	1	3,803	4
Escambia	104/M	42	62	4,362	270
Mobile	58/M	54	4	43,592	174
Monroe	85/M	73	12	1,615	19
Washington	85/B	84	1	1,682	2
TOTAL				145,314	7,327

B - Biloxi
M - Montgomery
T - Tuskegee
LC - Lake City

Map 3
Okaloosa County (Ft. Walton Beach MSA) and Theoretical PSA

Plus --

District 10 Counties:

Seminole, GA
Baldwin, AL
Coffee, AL
Conecuh, AL
Covington, AL
Escambia, AL
Geneva, AL
Houston, AL
Monroe, AL

PSA Population

1990 - 120,523
1995 - 124,813
2000 - 126,373
2010 - 143,100

TABLE 3

OKALOOSA COUNTY PSA - Distance and Population Data

PSA Counties	1 Distance from Nearest Hospital (Miles)	2 Distance from Site	3 Difference (Column 1 - Column 2)	4 Veteran Population (1995)	5 Access Index (Column 3 X Column 4 ÷ 1000)
OKALOOSA	117/B	0	117	12,990	1,520
Bay	154/M	63	91	14,780	1,345
Calhoun	140/T	88	52	1,080	56
Escambia	106/B	41	65	32,630	2,121
Franklin	138/LC	116	22	1,120	25
Gadsden	123/LC	116	7	3,580	25
Gulf	158/LC	92	66	1,300	86
Holmes	107/M	51	56	2,140	120
Jackson	115/T	81	34	4,450	151
Liberty	136/LC	100	36	520	19
Santa Rosa	117/B	30	87	8,510	740
Walton	113/M	27	86	3,340	287
Washington	118/T	57	61	1,860	113
Decatur, GA	124/LC	121	3	2,347	7
Seminole	110/T	105	5	830	4
Baldwin, AL	77/B	71	6	7,696	46
Coffee	71/M	65	6	4,787	29
Conecuh	75/M	61	14	1,581	22
Covington	75/M	47	28	3,803	106
Escambia	104/M	54	50	4,362	218
Geneva	91/M	57	34	2,582	88
Houston	86/T	83	3	6,970	21
Monroe	85/M	80	5	1,615	8
TOTAL				124,813	7,157

M - Montgomery
T - Tuskegee

B - Biloxi
LC - Lake City

Brevard County (Melbourne-Titusville-Cocoa MSA) and Theoretical PSA

PSA Population

1990 - 259,220
1995 - 277,190
2000 - 285,790
2010 - 214,330

TABLE 4
BREVARD COUNTY PSA - Distance and Population Data

PSA Counties*	1 Distance from Nearest Hospital (Miles)	2 Distance from Site	3 Difference (Column 1 - Column 2)	4 Veteran Population (1995)	5 Access Index (Column 3 X Column 4 ÷ 1000)
BREVARD	108/T	0	108	48,320	5,219
Indian River	125/T	47	78	11,290	881
Martin	93/M	84	9	14,010	126
Okeechobee	108/M	70	38	3,160	120
Orange	75/T	46	29	85,700	2,485
Osceola	68/T	41	27	9,770	264
St. Lucie	113/M	63	50	16,350	818
Seminole	84/T	47	37	38,930	1,440
Volusia	84/G	62	22	49,660	1,093
TOTAL				277,190	12,446

G - Gainesville
T - Tampa
M - Miami

Map 5
Orange County (Orlando MSA) and Theoretical PSA

PSA Population

1990 - 268,620
1995 - 287,050
2000 - 295,800
2010 - 222,780

TABLE 5
ORANGE COUNTY PSA - Distance and Population Data

PSA Counties	1 Distance from Nearest Hospital (Miles)	2 Distance from Site	3 Difference (Column 1 - Column 2)	4 Veteran Population (1995)	5 Access Index (Column 3 X Column 4 ÷ 1000)
ORANGE	75/T	0	75	85,700	6,428
Brevard	108/T	46	62	48,320	2,996
Flagler	69/G	64	5	2,000	10
Indian River	125/T	86	39	11,290	440
Lake	69/T	28	41	17,780	729
Okeechobee	108/M	94	14	3,160	44
Osceola	68/T	20	48	9,770	469
St. Lucie	113/M	100	13	16,350	213
Seminole	84/T	12	72	38,930	2,803
Sumter	58/T	44	14	4,090	57
Volusia	84/G	44	40	49,660	1,986
TOTAL				287,050	16,175

T - Tampa
G - Gainesville
M - Miami

Map 6
Seminole County (Orlando MSA) and Theoretical PSA

PSA Population

1990 - 268,620
1995 - 287,050
2000 - 295,800
2010 - 222,780

TABLE 6

SEMINOLE COUNTY PSA - Distance and Population Data

PSA Counties	1 Distance from Nearest Hospital (Miles)	2 Distance from Site	3 Difference (Column 1 - Column 2)	4 Veteran Population (1995)	5 Access Index (Column 3 X Column 4 ÷ 1000)
SEMINOLE	84/T	0	84	38,930	3,270
Brevard	108/T	47	61	48,320	2,948
Flagler	69/G	52	17	2,000	34
Indian River	125/T	91	34	11,290	384
Lake	69/T	28	41	17,780	729
Okeechobee	108/M	103	5	3,160	16
Orange	75/T	12	63	85,700	5,399
Osceola	68/T	31	37	9,770	361
St. Lucie	113/M	106	7	16,350	114
Sumter	58/T	46	12	4,090	49
Volusia	84/G	32	52	49,660	2,582
TOTAL				287,050	15,886

T - Tampa
G - Gainesville
M - Miami

Map 7
Volusia County (Daytona Beach MSA) and Theoretical PSA

PSA Population

1990 - 254,830
1995 - 272,180
2000 - 280,360
2010 - 215,370

TABLE 7

VOLUSIA COUNTY PSA - Distance and Population Data

PSA Counties	1 Distance from Nearest Hospital (Miles)	2 Distance from Site	3 Difference (Column 1 - Column 2)	4 Veteran Population (1995)	5 Access Index (Column 3 X Column 4 ÷ 1000)
VOLUSIA	84/G	0	84	49,660	4,171
Brevard	108/T	63	45	48,320	2,174
Flagler	69/G	24	45	2,000	90
Indian River	125/T	110	15	11,290	169
Lake	69/T	47	22	17,780	391
Orange	75/T	44	31	85,700	2,657
Osceola	68/T	62	6	9,770	59
St. Johns	61/G	56	5	8,730	44
Seminole	84/T	32	52	38,930	2,024
TOTAL				272,180	11,779

G - Gainesville
T - Tampa

Map 8
Duval County (Jacksonville MSA) and Theoretical PSA

TABLE 8

DUVAL COUNTY PSA - Distance and Population Data

PSA Counties	1 Distance from Nearest Hospital (Miles)	2 Distance from Site	3 Difference (Column 1 - Column 2)	4 Veteran Population (1995)	5 Access Index (Column 3 X Column 4 ÷ 1000)
DUVAL	60/LC	0	60	83,170	4,990
Clay	41/C	25	16	12,340	197
Flagler	69/C	63	6	2,000	12
Nassau	68/LC	21	47	5,610	264
St. Johns	61/C	32	29	8,730	253
Brantley, GA	81/LC	63	18	973	18
Camden	75/LC	36	39	1,486	58
Charlton	59/LC	40	19	688	13
Glynn	98/LC	60	38	7,452	283
McIntosh	114/D	80	34	767	26
Pierce	84/LC	77	7	1,226	9
TOTAL				124,442	6,123

LC - Lake City
C - Gainesville
D - Dublin

47-660 O—85——4

Map 9
Lee County (Ft. Myers-Cape Coral MSA) and Theoretical PSA

PSA Population

1990 - 112,670
1995 - 121,990
2000 - 127,010
2010 - 50,410

TABLE 9

LEE COUNTY PSA - Distance and Population Data

PSA Counties	1 Distance from Nearest Hospital (Miles)	2 Distance from Site	3 Difference (Column 1 - Column 2)	4 Veteran Population (1995)	5 Access Index (Column 3 X Column 4 ÷ 1000)
LEE	100/T	0	100	43,440	4,344
Charlotte	74/T	26	48	14,450	694
Collier	93/M	31	62	18,870	1,170
DeSoto	64/T	40	24	3,080	74
Glades	95/M	50	45	750	34
Hendry	84/M	45	39	2,710	106
Highlands	70/T	65	5	7,890	39
Indian River	125/T	114	11	11,290	124
Okeechobee	108/M	79	29	3,160	92
St. Lucie	113/M	109	4	16,350	65
TOTAL				121,990	6,742
(Sarasota)	43/BP	60		(41,170)	

T - Tampa
M - Miami
BP - Bay Pines

Map 10
Sarasota County (Sarasota MSA) and Theoretical PSA

PSA Population

1990 - 133,580
1995 - 144,070
2000 - 149,560
2010 - 64,050

TABLE 10

SARASOTA COUNTY PSA - Distance and Population Data

PSA Counties	1 Distance from Nearest Hospital (Miles)	2 Distance from Site	3 Difference (Column 1 - Column 2)	4 Veteran Population (1995)	5 Access Index (Column 3 X Column 4 ÷ 1000)
SARASOTA	48/T	0	48	41,170	1,976
Manatee	35/T	16	19	27,270	518
Hardee	47/T	45	2	2,860	6
DeSoto	64/T	39	25	3,080	77
Charlotte	74/T	35	39	14,450	564
Lee	100/T	58	42	43,440	1,824
Glades	95/M	87	8	750	6
Highlands	70/T	67	3	7,890	24
Okeechobee	108/M	103	5	3,160	16
TOTAL				144,070	5,011

M - Miami
T - Tampa

Map 11
Leon County (Tallahassee MSA) and Theoretical PSA

Plus —

District 9 Counties:

Baker, GA
Calhoun, GA
Dougherty, GA
Worth, GA

District 10 Counties:

Early, GA
Seminole, GA
Houston, AL

PSA Population

1990 - 100,404
1995 - 103,994
2000 - 105,444
2010 - 103,400

TABLE 11
LEON COUNTY PSA - Distance and Population Data

PSA Counties	1 Distance from Nearest Hospital (Miles)	2 Distance from Site	3 Difference (Column 1 - Column 2)	4 Veteran Population (1995)	5 Access Index (Column 3 X Column 4 ÷ 1000)
LEON	100/LC	0	100	23,850	2,385
Bay	154/M	83	71	14,780	1,049
Calhoun	140/T	49	91	1,080	98
Franklin	138/LC	59	79	1,120	88
Gadsden	123/LC	24	99	3,580	354
Gulf	158/LC	69	89	1,300	116
Holmes	107/M	93	14	2,140	30
Jackson	115/T	61	54	4,450	240
Jefferson	77/LC	25	52	1,180	61
Liberty	136/LC	38	98	520	51
Madison	53/LC	49	4	1,490	6
Taylor	56/LC	49	7	2,420	17
Wakulla	103/LC	21	82	1,790	147
Walton	113/M	112	1	3,340	3
Washington	118/T	82	36	1,860	67
Baker, GA	107/T	60	47	316	15
Brooks	72/LC	50	22	1,217	27
Calhoun	87/T	77	10	412	4
Colquitt	97/LC	59	38	3,436	131
Cook	82/LC	70	12	1,221	15
Decatur	124/LC	34	90	2,347	211
Dougherty	97/D	77	20	11,952	239
Early	88/T	51	37	937	35
Grady	106/LC	30	76	1,931	147
Miller	104/T	56	48	563	27
Mitchell	115/LC	52	63	1,491	94
Seminole	110/T	51	59	830	49
Thomas	91/LC	35	56	3,737	209
Worth	86/D	79	7	1,734	12
Houston, AL	86/T	82	4	6,970	28
TOTAL				103,994	5,955

LC - Lake City
M - Montgomery
T - Tuskegee
D - Dublin

Map 44
Palm Beach County (West Palm-Boca Raton MSA) and Theoretical PSA

PSA Population

1990 - 147,530
1995 - 158,940
2000 - 164,870
2010 - 80,110

TABLE 12
PALM BEACH COUNTY PSA - Distance and Population Data

PSA Counties	1 Distance from Nearest Hospital (Miles)	2 Distance from Site	3 Difference (Column 1 - Column 2)	4 Veteran Population (1995)	5 Access Index (Column 3 X Column 4 ÷ 1000)
PALM BEACH	59/M	0	59	110,670	6,530
Glades	95/M	64	31	750	23
Hendry	84/M	63	21	2,710	57
Indian River	125/T	71	54	11,290	610
Martin	93/M	35	58	14,010	813
Okeechobee	108/M	60	48	3,160	152
St. Lucie	113/M	55	58	16,350	948
TOTAL				158,940	9,133
(Broward)	23/M	37		(209,510)	

M - Miami
T - Tampa

Map 13
Broward County (Fort Lauderdale MSA) and Theoretical PSA

PSA Population

1990 - 342,370
1995 - 368,450
2000 - 370,190
2010 - 191,470

TABLE 13

BROWARD COUNTY PSA - Distance and Population Data

PSA Counties	1 Distance from Nearest Hospital (Miles)	2 Distance from Site	3 Difference (Column 1 - Column 2)	4 Veteran Population (1995)	5 Access Index (Column 3 X Column 4 ÷ 1000)
BROWARD	23/M	0	23	209,510	4,819
Palm Beach	59/M	37	22	110,670	2,435
Hendry	84/M	72	12	2,710	33
Glades	95/M	81	14	750	11
Martin	93/M	71	22	14,010	31
Okeechobee	108/M	88	20	3,160	63
St. Lucie	113/M	91	22	16,350	360
Indian River	125/T	106	19	11,290	215
TOTAL				368,450	7,967

Appendix II

Map 1A
GAINESVILLE/LAKE CITY PSA
(Before and After Proposed Hospitals in
Brevard County and Panhandle Area*)

	Vet Population Served	Beds/1000 Veterans
1982 PSA	283,221	2.96
1995 PSA	270,247	3.10

*If proposed Panhandle hospital is placed in Escambia County

Map 1B
GAINESVILLE/LAKE CITY PSA
(Before and After Proposed Hospitals in
Brevard County and Panhandle Area*)

	Vet Population Served	Beds/1000 Veterans
1982 PSA	283,221	2.96
1995 PSA	265,027	3.16

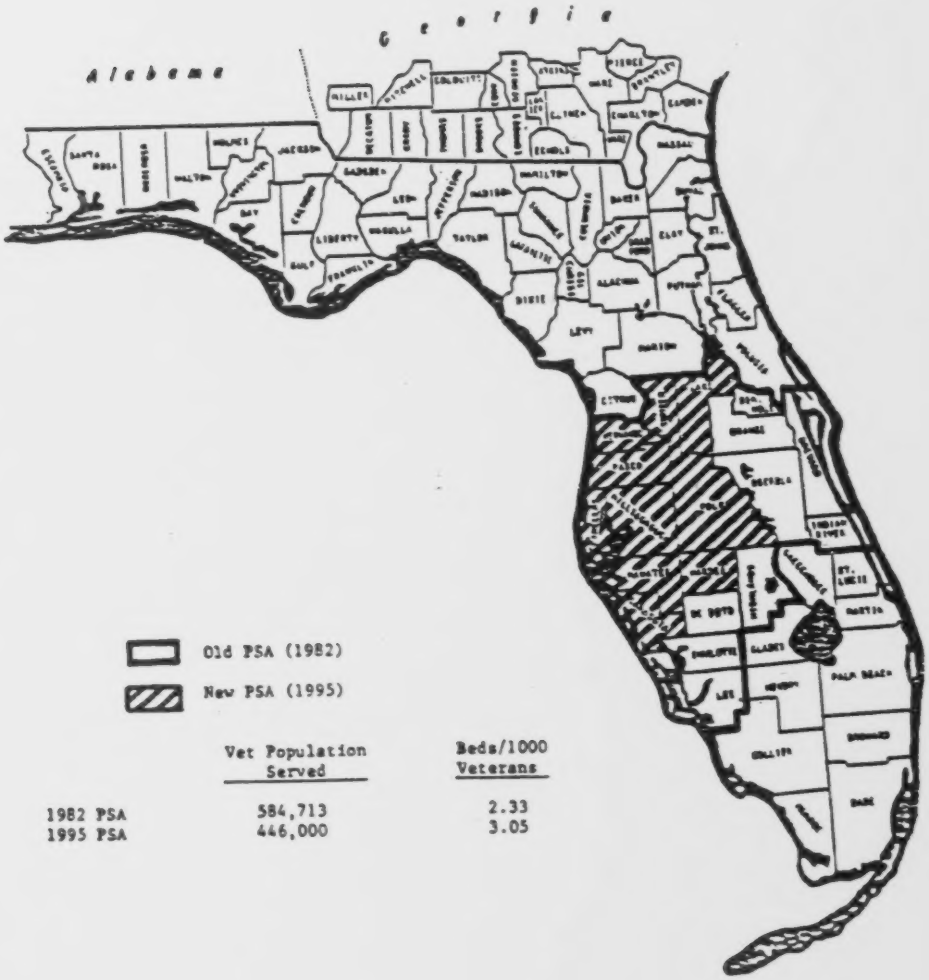
*If proposed Panhandle hospital is placed in Okaloosa County

Map 1C
GAINESVILLE/LAKE CITY PSA
(Before and After Proposed Hospitals in
Brevard County and Panhandle Area*)

	Vet Population Served	Beds/1000 Veterans
1982 PSA	283,221	2.96
1995 PSA	235,965	3.55

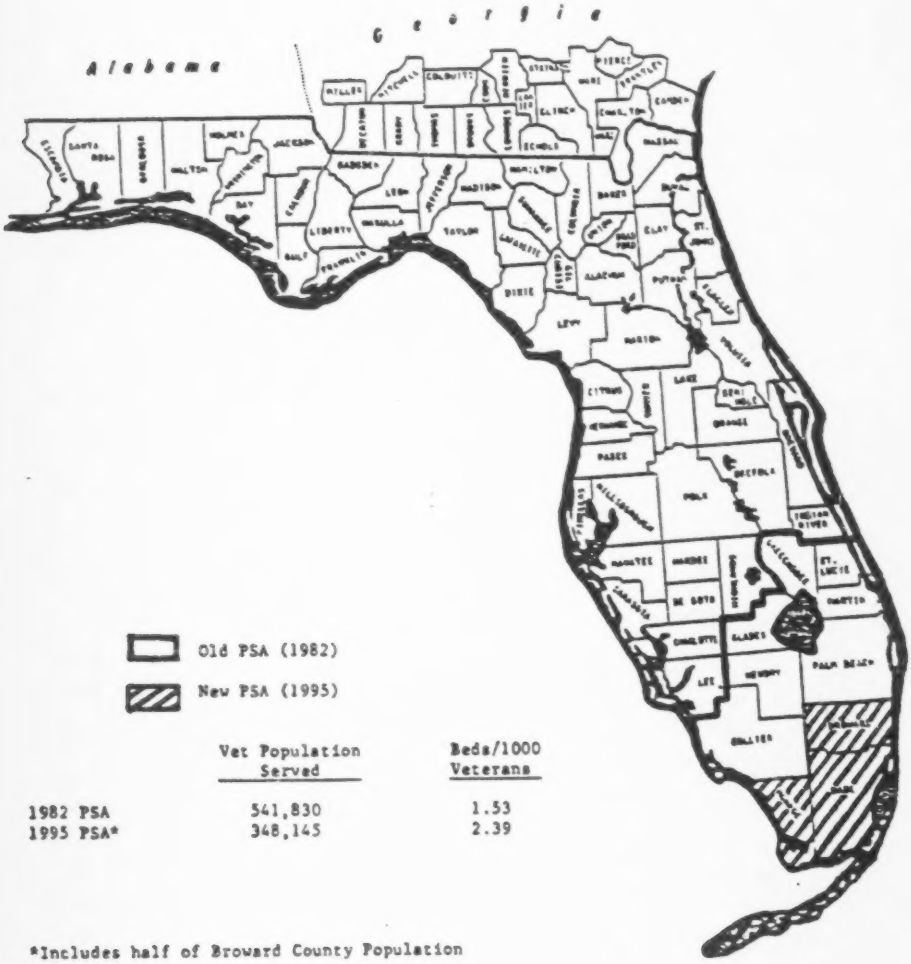
*If proposed Panhandle hospital is placed in Bay County

Map 2
BAY PINES/TAMPA PSA
(Before and After Proposed Hospitals in
Brevard and Lee County)



	Vet Population Served	Beds/1000 Veterans
1982 PSA	584,713	2.33
1995 PSA	446,000	3.05

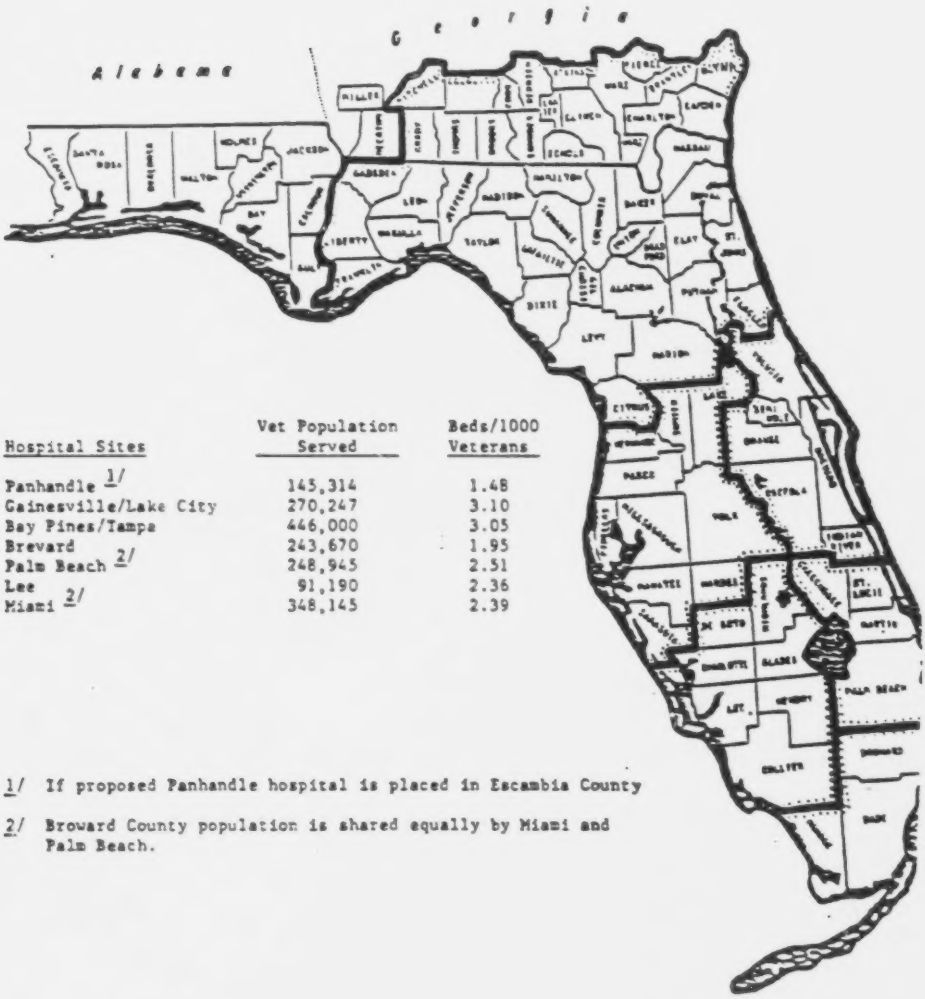
Map 3
MIAMI PSA
(Before and After Proposed Hospitals in
Palm Beach County and Lee County)



	Vet Population Served	Beds/1000 Veterans
1982 PSA	541,830	1.53
1995 PSA*	348,145	2.39

*Includes half of Broward County Population

Map 4A
PSAs After Feasible Hospitals are Added (1995)

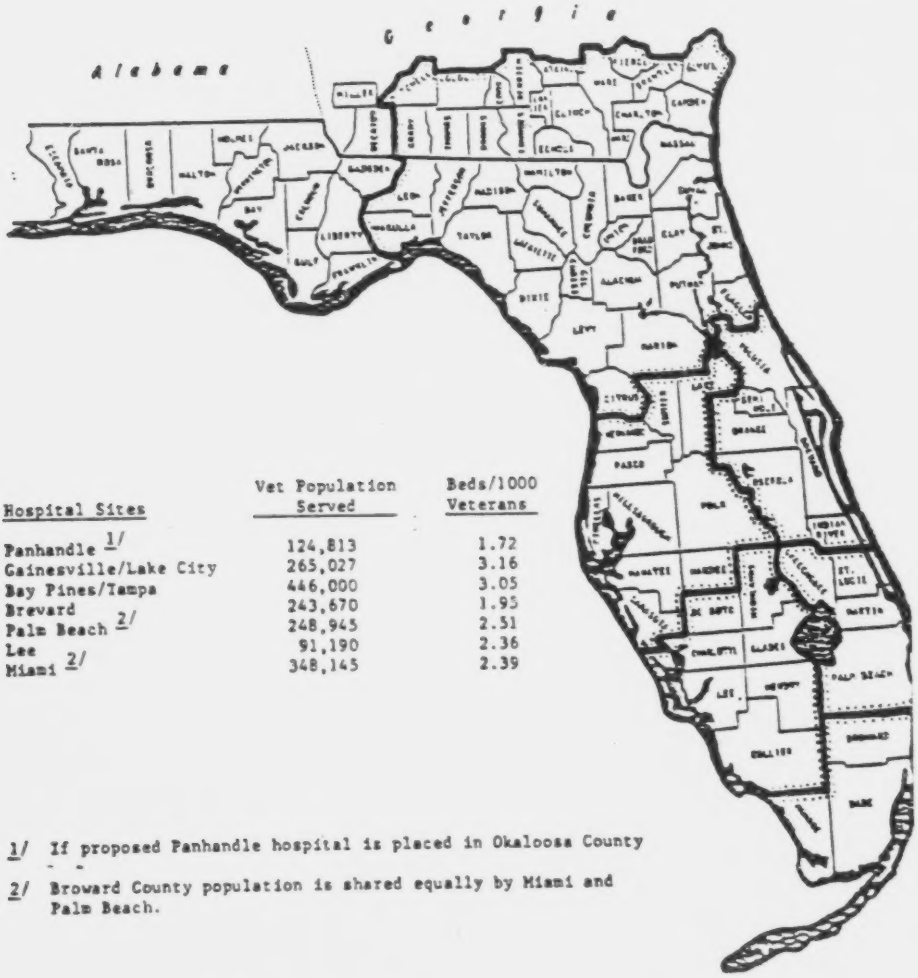


Hospital Sites	Vet Population Served	Beds/1000 Veterans
Panhandle 1/	145,314	1.48
Gainesville/Lake City	270,247	3.10
Bay Pines/Tampa	446,000	3.05
Brevard	243,670	1.95
Palm Beach 2/	248,945	2.51
Lee	91,190	2.36
Miami 2/	348,145	2.39

1/ If proposed Panhandle hospital is placed in Escambia County

2/ Broward County population is shared equally by Miami and Palm Beach.

Map 4B
PSAs After Feasible Hospitals are Added (1995)

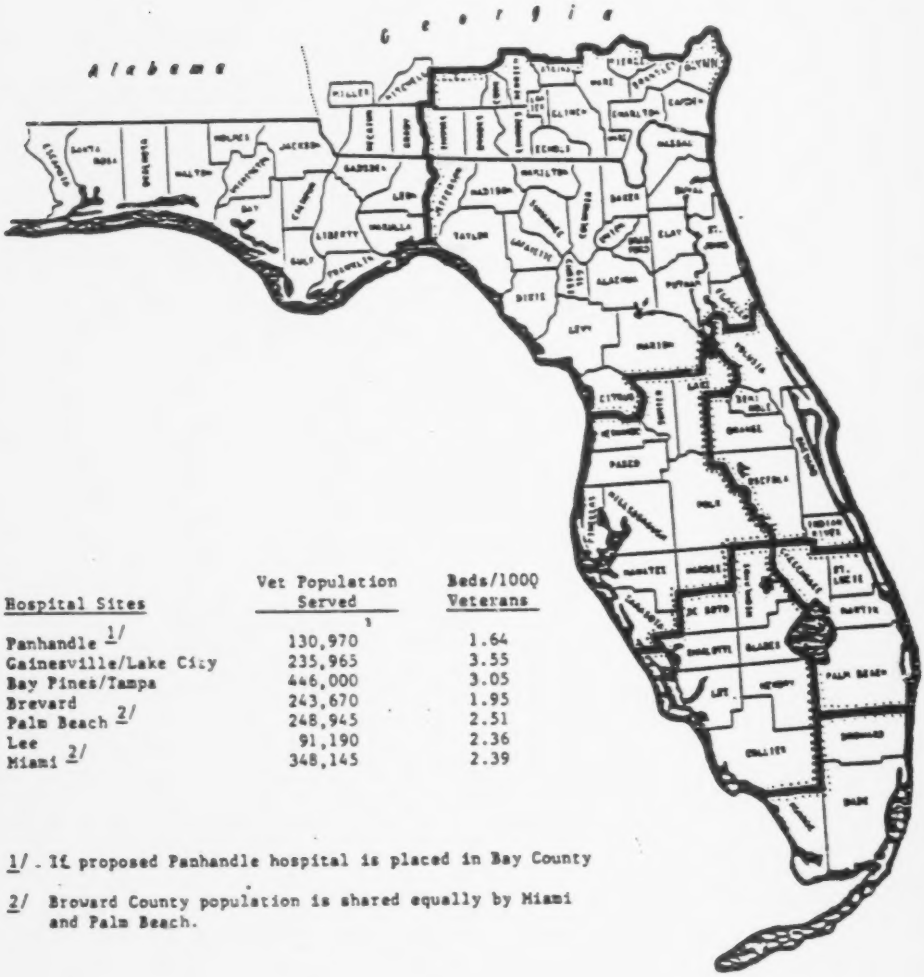


Hospital Sites	Vet Population Served	Beds/1000 Veterans
Panhandle 1/	124,813	1.72
Gainesville/Lake City	265,027	3.16
Bay Pines/Tampa	446,000	3.05
Brevard	243,670	1.95
Palm Beach 2/	248,945	2.51
Lee	91,190	2.36
Miami 2/	348,145	2.39

1/ If proposed Panhandle hospital is placed in Okaloosa County

2/ Broward County population is shared equally by Miami and Palm Beach.

Map 4C
PSAs After Feasible Hospitals are Added (1995)



Hospital Sites	Vet Population Served	Beds/1000 Veterans
Panhandle 1/	130,970	1.64
Gainesville/Lake City	235,965	3.55
Bay Pines/Tampa	446,000	3.05
Brevard	243,670	1.95
Palm Beach 2/	248,945	2.51
Lee	91,190	2.36
Miami 2/	348,145	2.39

1/ . If proposed Panhandle hospital is placed in Bay County

2/ Broward County population is shared equally by Miami and Palm Beach.

REPORT OF VISIT
PROVIDENCE HOSPITAL
MOBILE, ALABAMA

1. PURPOSE

At the request of the Office of the Administrator, officials of the Department of Medicine and Surgery and the Office of Construction conducted a facility survey of the Providence Hospital on March 26 - 28, 1984. The purpose of this visit was to review the facilities of the Providence Hospital, determine the condition of the hospital, and consider its potential adaptability for use as a Veterans Administration Medical Center.

2. BACKGROUND

The Providence Hospital is an acute medical and surgical facility located at 1504 Springhill Avenue, Mobile, Alabama, 36652. The hospital is operated under the auspices of the Daughters of Charity of St. Vincent DePaul. Providence is currently in the process of constructing a new facility on Airport Boulevard several miles to the west of the present facility. The new Providence Hospital is expected to be completed and occupied in September 1986. At that time, the existing facility would become available for other use. The coming availability of the Providence Hospital has resulted in a proposal that the VA establish a medical center at the Providence location. This proposal has wide support within the community from veterans organizations, elected officials and other civic leaders. As a result of this interest, the VA agreed to visit and inspect the facility. In Mobile, VA representatives were given a comprehensive tour of the facilities and provided with drawings and other technical information. The VA team also held discussions with a variety of community leaders including the Mayor of Mobile, representatives of veteran service organizations, the President of the University of South Alabama and the Dean of the Medical School.

3. FACILITY DESCRIPTION

The Providence medical complex is comprised of a main hospital building of approximately 440,626 gross square feet, an adjacent School of Nursing of approximately 69,064 gross square feet and an employee residence of approximately 9,850 gross square feet. The complex is situated on a 15.3 acre site including paved parking for 1,000 cars. The hospital is accredited by the Joint Commission on the Accreditation of Hospitals. The entire complex is offered to the Veterans Administration for $24,000,000. The price does not include equipment items; however, we were advised that much of the equipment could be negotiable. The main building was constructed in four phases:

1952 Wing	158,818 square feet
1965 Addition	32,216 square feet
1972 Addition	156,267 square feet
1982 Ancillary Wing	97,325 square feet

The hospital is presently providing 349 beds for acute medical care and 34 additional stations for renal dialysis treatment.

Report of Visit, Providence Hospital, Mobile, Alabama (Continued)

A. Support Systems

1. Pneumatic tube communication system to all major departments.
2. Medical oxygen, vacuum and nurse call in all patient rooms.
3. AT&T Dimension telephone system in all rooms.
4. Television hookups in all patient rooms.

B. Clinical Support

1. Large laboratory service.
2. Large pharmacy service.
3. Expanded radiology department, including radiation therapy.
4. Cardio pulmonary lab and respiratory therapy department.
5. Outpatient surgery department.
6. Small rehabilitation medicine service.
7. Surgical department including eight operating rooms, two cystoscopy rooms, one special procedure room, and one laser therapy suite.

C. Education Support

1. Twelve large classrooms of 300 net square feet and above.
2. 300 seat auditorium.
3. 2,100 square foot library.

D. Administrative and General Support

1. Institutional sized kitchen, capable of producing 4,000 meals per day.
2. A 175 seat employee cafeteria.
3. Eight spacious lobbies and waiting areas.
4. Gift and coffee shop.
5. Computer and word processor linkages between major departments.
6. Administrative suite and offices throughout the building.
7. Warehouse with dock and freight elevator.
8. Two large maintenance shops with storage areas.
9. Laundry facility.

In addition to the main hospital building, there is a five story, 120 bed School of Nursing, with a library and conference/classroom space. A two story 13 bedroom employee residence with three car garage is also included in the parcel.

4. FACILITY CONDITION

A. Architectural

(1) Space and Functional Analysis: The nursing units are comprised of one and two bedrooms with private and shared bathrooms and toilets. The bathrooms do not meet VA criteria for handicapped accessibility. The bedrooms are comparable in size to VA

hospital bedrooms. The ward designs are acceptable but do not contain the same support functions as VA nursing units. Education space is more than adequate for VA purposes. Outpatient and Ambulatory Care space is minimal and would require expansion to meet VA standards. Existing support services such as Radiology, Pharmacy, Laboratory are adequate in size but may require expansion depending on program needs. Rehabilitation Medicine would require expansion to meet VA program needs. There are other programs such as Dental Service, Speech Pathology and Substance Abuse that would require space not presently in the program at the Providence Hospital. The surgical suite is comparable to the VA design and would not require any additional space.

(2) Floors: All floors throughout the main hospital building are either vinyl tile or carpeted. All floors are well maintained and in good condition.

(3) Ceiling: Most ceilings in the hospital are the "lay-in" type with the exception of surgery and other areas requiring plaster. All ceilings are in good condition.

(4) Corridors: Most corridors throughout the hospital are either seven (7) or eight (8) feet in width and are equipped with handicapped rails.

(5) Ramping for the handicapped between old and new wings is steeper than the national standard.

(6) Most partitions are of gypsum board construction and well maintained through routine painting.

(7) All bedrooms have at least one window and natural light seems adequate.

B. Mechanical

(1) Steam System

(a) General

(1) The boiler plant has two Murray high pressure steam water tube boilers rated at 20,000 pounds of steam per hour each. The boiler can be fired on natural gas or No. 2 oil. Gas is considered the primary fuel. Two 10,000 gallon oil storage tanks provide fuel for standby operation.

Report of Visit, Providence Hospital, Mobile, Alabama (Continued)

(2) The boiler plant is complete with all auxillary equipment including boiler controls, condensate storage tank, condensate transfer pump, feedwater deaerator, feedwater pumps, and a fuel oil pump. There is a masonry stack extending the full height of the building.

(3) The steam is not metered. However, hospital personnel report one boiler can handle the normal steam loads. The second boiler is available for standby operation. The two Murray high pressure steam boilers were replaced as part of the 1972 building addition. The deareator and boiler feed pumps were also replaced at this time.

(b) Distribution System

(1) Steam is distributed at 125 psig pressure and reduced at local pressure reducing stations as required. Steam condensate is collected in each building and returned to the boiler plant by pumped condensate return systems.

(2) The steam distribution system provides steam to the kitchen, laundry, sterilizers, various building heating systems, humidifiers, domestic hot watear heaters and the steam turbine chiller.

(3) With the kitchen, laundry absorption chiller, and steam turbine chiller in operation, the summer steam loads may exceed the winter steam loads.

(2) Chilled Water System

(a) General

(1) Chilled water for the HVAC systems is provided by five water chillers. The five chillers are located in the following four areas of the hospital:

(a) A 250 ton Carrier chiller (1952) driven by a Worthington steam turbine (1952) and a 600 ton carrier centrifugal chiller (1972) are located in the boiler plant.

Report of Visit, Providence Hospital, Mobile, Alabama (Continued)

(b) A 125 ton Carrier centrifugal chiller (1952) is located on the Ground Floor of the 1972 addition.

(c) A 225 ton Trane absorption chiller (1974) is housed in a prefabricated steel building located in the courtyard north of the boiler plant.

(d) A 400 ton Trane centrifugal chiller (1982) is located on the Ground Floor of the 1982 addition.

(b) Distribution System

(1) All of the chillers, with the exception of the 400 ton chiller located in the 1982 addition, serve a common primary chilled water loop. Secondary piping systems provide chilled water to each of the buildings.

(2) Each chiller has a condensing water system consisting of a cooling tower, condenser water pump and related piping.

(3) Heating, Ventilating and Air Conditioning Systems

(a) General

(1) The existing Providence Hospital was constructed in several phases. The oldest wing of the hospital dates back to 1952. Other major additions were added in 1959, 1963, 1972, and 1982.

(2) Several types of heating, ventilating and air conditioning systems have been applied to each of these buildings.

(4) Mechanical Comments

These comments are based on a preliminary inspection of the physical plant. (If the Veterans Administration were to acquire the existing Providence Hospital an in-depth study of the existing systems would be required.)

(1) Boiler Plant

(a) The existing plant appears to be adequate in capacity for existing loads.

Report of Visit, Providence Hospital, Mobile, Alabama (Continued)

(b) Major deficiencies:

(1) Lack of instrumentation to cover steam output, burner performance, combustion efficiency.

(2) Lack of boiler properly sized for off season (summer) loads results in inefficient operation. There is no space in the existing plant to add a summer boiler.

(3) The boilers are located below grade, contrary to VA Criteria. Maintenance and operating space around the boiler is surely restricted.

(4) Due to lack of instrumentation, the capability of the plant to handle load increases is unknown. Load increases could arise due to changes in HVAC or other systems.

(c) A new boiler plant is recommended. It is not practical to modify the existing plant because of space restrictions and location problems (below grade).

(2) Chilled Water System

(a) The steam turbine driven chiller, located in the boiler plant, is inefficient and should be replaced.

(b) At the present time the operating rooms are served from the primary chilled water loop. A dedicated chiller on the essential power system should be provided for the operating rooms.

(3) Operating Rooms

(a) Air distribution in the operating rooms does not meet current VA Criteria:

(1) All air supplied to operating rooms should be delivered from ceiling outlets.

Report of Visit, Providence Hospital, Mobile, Alabama (Continued)

(2) All exhaust air from the area shall be removed near floor level with at least two outlets.

(3) Stainless steel duct work shall be in accordance with VA Criteria.

(b) Operating rooms require individual terminal humidity control. The existing humidifiers at Providence Hospital have been disconnected.

(4) Supply, Processing and Distribution

(a) All duct work from the sterilizing equipment should be stainless steel.

(b) A dedicated exhaust system with stainless steel ductwork must be applied to the ethylene oxide sterilizers.

C. Electrical

(1) Primary and Secondary Distribution Systems

(a) There are two incoming underground services supplying electric power to Providence Hospital. The preferred line comes in at 22 KV and stepped down to 4.16 KV. The other is 4160 volt with two 2500 KVA transformers; the standby line comes in at 4.16 KV.

(b) The power is distributed through a line-up of 5 KV fused load interrupter switches and, then goes underground to a 1500 KV padmounded transformer and two transformer vaults.

(c) The 1500 KVA padmound transformer serve the new addition (ancillary wing) with 480/277 volt. The two transformer vaults with exposed 5 KV switches and two banks of single phase transformers each (1500 KVA, 700 KVA) (100 KVA, 500 KVA) serve the older buildings with 480/277 volt and 208/120 volt.

(d) Although the new addition meets the latest code the older buildings should be upgraded and the following proposals are recommended:

(1) Replace the primary fused switch line-up with walk-in switchgear.

(2) Run additional primary feeders to areas where required.

Report of Visit, Providence Hospital, Mobile, Alabama (Continued)

(3) Replace exposed 5 KV switches with enclosed type selector switchs were required.

(4) Replace all single phase transformers.

(5) Replace and relocate old secondary switchgear to a longer room because it is impossible to remove defective equipment out of this room due to the fact that an added section of switchgear was built right at the entrance of this room.

(6) Replace old panels.

(7) Replace wiring in areas where green grounding conductors do not exist and replace conduit if necessary.

(2) Emergency Power

There are two 600 KW generators serving the older buildings which include ICU's and operating rooms. Both generators can be selected to serve the critical loads. In addition, there is one 325 KW generator serving the Ancillary Wing. This system is divided into Life Safety, Critical and Equipment branches.

(3) Fire Alarm

(a) There are two non-coded fire alarm systems in good working condition. One serves the Ancillary Wing and the other serves the older buildings.

(b) The two fire alarm systems should be incorporated into one system and upgraded to a zone-coded PNIS System as required by the VA.

(4) Elevators

(a) There are two, three and four banks of elevators in the hospital. The bank of three elevators were installed in 1982 and the other banks were installed along with each addition.

(b) All of these elevators appears to be well maintained and in good running condition.

(c) There is also one small elevator in the School of Nursing.

Report of Visit, Providence Hospital, Mobile, Alabama (Continued)

D. Safety

A fire safety specialist did not participate in this visit and it is recommended that a detailed analysis using the Fire Safety Equivalency System be conducted as part of any further assessment. The JCAH report has noted deficiencies in door louvers and transoms and in duct penetration of smoke stop partitions.

E. Structural

(1) The existing Providence Hospital and the structural additions were designed for lower live loads then the current VA design.

(2) Any future use of the Providence Hospital for VA purposes would require careful coordination of the proposed functional areas with the load bearing capability of the existing structural framing.

4. CONCLUSIONS:

The VA team concluded that the Providence Hospital is well maintained and in generally good condition. The newest construction is in excellent condition. As indicated previously, the hospital would require certain modifications if a VA medical center were to be established. It would be difficult at this time to estimate the cost of these modifications without the establishment of a service level and space program. The team has not attempted to do so. It is the team's belief that if a programmatic determination were made to establish a VA medical center in Mobile, the Providence Hospital could be adapted to serve in this role. A detailed analysis would be needed to determine the cost of modifying Providence and thus the true cost of acquisition.

ROBERT L. NEARY, Jr.
Director, Facility Planning Service
Department of Medicine and Surgery

HOWELL HEFLIN
ALABAMA

United States Senate
WASHINGTON, D.C. 20510

March 15, 1985

Honorable Richard C. Shelby
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

I am pleased to see that you have chosen to hold a hearing on the proposal for the establishment of a Veterans Administration Hospital in the City of Mobile, Alabama. I have supported the proposal of converting the Providence Hospital to a VA Medical Center since the idea was conceptualized and continue to give this project my unqualified endorsement.

I have contacted the Administrator of the Veterans Administration, Mr. Harry N. Walters, since the beginning of the planning for this project and encouraged him to conduct a thorough study of the proposal. After touring the Providence Hospital in October, 1984 and talking with the Veterans of the Gulf Coast area, I became even more strongly convinced that a Veterans Hospital is necessary. In early January, 1984, the Regional Office of the Veterans Administration issued an analysis of the Providence Hospital proposal. This report recommended that the Veterans Administration not acquire the Providence Hospital. On January 21, 1985, I contacted the V.A. Administrator and reiterated my support of this project. The Administrator agreed to another review of the proposal. I have continued to contact the Administrator on this matter and recently met with members of the Veteran's Hospital Committee in my Washington Office.

The existing long-range plan for VA District 10, which includes Northwest Florida, and the State of Mississippi and Alabama, highlights the need for a major VA medical facility on the Northern Gulf Coast. The veteran population of this area is expected to increase and the average age of veterans will increase sharply. A large number of older veterans in future years will put increasing demands on the need for adequate veterans health care.

Our veterans should not have to drive to Birmingham or New Orleans to be treated for a serious illness. We owe our veterans more than that. Veterans are merely asking for adequate health care within a reasonable distance of their homes. This is not an unreasonable request.

With the need for an additional VA medical center in the Northern Gulf Coast firmly established, the questions which should be asked now are: Where should we locate the hospital, and how much should we spend? The answers: Mobile is centrally located and would easily service the entire Northern Gulf Coast, and Providence Hospital is a bargain. Converting Providence Hospital to a VA facility would cost only about 20% as much as constructing a completely new hospital. At a time when our nation is faced with crippling deficits and forced to cut essential services and programs, it would be ludicrous to spend tens of millions of dollars on a new hospital when we have a perfectly good facility almost ready to be occupied. The purchase of the Providence Hospital as a VA medical center is our only logical decision.

Mr. Chairman, I thank you for the opportunity to present this letter to your committee. I believe this hearing will help focus the attention of the Congress and the Administration on the advantages of the Providence Hospital proposal.

Sincerely,

Howell Heflin

HH/csb

TESTIMONY OF

DONALD B. THOMPSON

DIRECTOR, SOUTHEASTERN REGION

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,

COMMITTEE ON VETERANS AFFAIRS,

HOUSE OF REPRESENTATIVES

MARCH 15, 1985

MOBILE, ALABAMA

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE AND GUESTS - I AM HONORED TO REPRESENT THE VETERANS ADMINISTRATION TODAY IN CONNECTION WITH THE CONSIDERATION OF A VA MEDICAL CENTER IN THE SOUTH ALABAMA - WESTERN PANHANDLE OF FLORIDA AREA. FIRST I WOULD LIKE TO RECOGNIZE THE EFFORTS OF A NUMBER OF PEOPLE IN THE MOBILE AREA WHO HAVE RESPONDED TO THE VA'S CHALLENGE OF MEETING THE HEALTH CARE NEEDS OF OUR VETERAN POPULATION BY SUGGESTING THE SITE OF MOBILE, ALABAMA FOR A VA MEDICAL CENTER.

I WOULD LIKE TO BEGIN MY TESTIMONY BY REFERRING TO TWO PREVIOUS REPORTS PREPARED BY THE VETERANS' ADMINISTRATION AT CONGRESSIONAL REQUEST. ON DECEMBER 23, 1981, A CONGRESSIONAL DIRECTIVE ACCOMPANYING PUBLIC LAW 97-101 MANDATED A 30 YEAR STUDY OF THE NEEDS OF VETERANS IN FLORIDA. THIS STUDY WAS DIRECTED DUE TO THE RAPID GROWTH OF THE VETERAN POPULATION IN THE FLORIDA AREA OVER THE PAST 2 DECADES AND THE EXPECTED GROWTH BY THE YEAR 2010. THE STUDY WAS LIMITED TO

MAR 12 1985

PROJECTING ESTIMATES OF HOSPITAL, DOMICILIARY AND NURSING HOME BEDS AND OUTPATIENT CARE NEEDS. INCLUDED IN THE GEOGRAPHICAL CONSIDERATIONS WERE ALL OF MEDICAL DISTRICT 12 (THE MAJORITY OF FLORIDA COUNTIES, INCLUDING 19 COUNTIES IN GEORGIA) AND THE 8 FLORIDA PANHANDLE COUNTIES OF MEDICAL DISTRICT 10.

AS AN OUTGROWTH OF THIS STUDY AND THE PURSUIT OF THE MEDICAL DISTRICT INITIATED PLANNING PROCESS (MEDIPP) , A SECOND REPORT WAS PUBLISHED IN JUNE 1983, THE FLORIDA PANHANDLE STUDY.

THE FINAL REPORT OF THE THIRTY YEAR STUDY BASED THE PROJECTED HOSPITAL BED NEEDS ON THE VA/GAO BED SIZING MODEL WHICH ASSUMES THAT THE HISTORIC RATES OF HOSPITAL USE WILL CONTINUE IN THE FUTURE. INPUT WAS RECEIVED FOR THESE STUDIES FROM MEDICAL DISTRICT 12 (FLORIDA), MEDICAL DISTRICT 10, VA MEDICAL CENTERS PLANNING COMMITTEES; VETERANS REVIEW GROUPS FOR MEDICAL DISTRICT PLANNING, THE DISTRICT PROFESSIONAL COUNCILS, THE DISTRICT ADMINISTRATIVE COUNCILS AND THE DISTRICT EXECUTIVE COUNCILS. IT WAS DETERMINED THAT THE "SUPPLY OF INPATIENT AND OUTPATIENT SERVICES SHOULD BE COMPARABLE TO NATIONAL LEVELS OF AVAILABILITY." THE STUDY CONSERVATIVELY PROJECTED THE NEED FOR AN ADDITION OF 1,525 BEDS IN FLORIDA BY THE YEAR 1995. THE STUDY ADDRESSED EXISTING VETERANS ADMINISTRATION FACILITIES, VETERAN POPULATION (CURRENT AND PROJECTED) USING THE FOLLOWING INDICES:

47-660 O—85——5

1) 1995 TOTAL VETERAN POPULATION IN A THEORETICAL PRIMARY SERVICE AREA (PSA)
2) 1995 VETERAN POPULATION OVER 50 MILES FROM AN EXISTING VA HOSPITAL BUT WITHIN 50 MILES OF A POTENTIAL SITE
3) 1995 VETERAN POPULATION OVER 75 MILES FROM AN EXISTING VA HOSPITAL BUT WITHIN 75 MILES OF AN EXISTING SITE
4) DISTANCE FROM THE POPULATION CENTER OF THE POTENTIAL, SITE TO THE NEAREST EXISTING VA HOSPITAL; AND,
5) PSA ACCESS INDEX, WHICH COMBINES DISTANCE AND POPULATION FACTORS TO MEASURE OVERALL POTENTIAL IMPROVEMENT IN ACCESS

OF PRIMARY CONSIDERATION WAS THAT NEW HOSPITALS SHOULD BE LOCATED AT SITES MORE THAN 75 MILES FROM EXISTING FACILITIES WHICH WOULD MINIMIZE THE NEGATIVE IMPACT ON THE UTILIZATION OF THOSE EXISTING OR PLANNED HOSPITALS. THIS EXHAUSTIVE STUDY WHICH REQUIRED 2 YEARS TO COMPLETE IDENTIFIED FOUR FINAL POTENTIAL SITES, INCLUDING:

1) PALM BEACH COUNTY - 625 BEDS
2) BREVARD COUNTY - 470 BEDS
3) ONE OF THE FLORIDA PANHANDLE COUNTIES - 215 BEDS (ONLY AFTER THE UTILIZATION OF AVAILABLE DEPARTMENT OF DEFENSE (DOD) BEDS IN LIEU OF NEW CONSTRUCTION BE EVALUATED)
4) LEE COUNTY - 215 BEDS

THE PLANNERS AGREED THAT THESE FACILITIES BE NON TEACHING HOSPITALS AND PROVIDE PREDOMINANTLY PRIMARY AND SECONDARY SERVICES.

THE MEDIPP PLANNING PROCESS HAS BEEN IN EFFECT SINCE 1981. IT IS THROUGH THIS PROCESS THAT THE VA IDENTIFIES PRESENT SERVICES, PROJECTED NEEDS, AND RECOMMENDED ADDITIONS, DELETIONS OR CHANGES IN SERVICES. A PLANNING BOARD CONSISTING OF PROFESSIONAL AND ADMINISTRATIVE PERSONS REPRESENTING ALL VAMC'S WITHIN A DISTRICT IS CHARGED WITH IDENTIFYING AREAS FOR CHANGE. AFTER CAREFUL STUDY, THE RECOMMENDATIONS OF THE PLANNING BOARD ARE REVIEWED BY COMMUNITY ADVISORY GROUPS INCLUDING SERVICE ORGANIZATION REPRESENTATIVES AND FINALLY BY THE DISTRICT EXECUTIVE COUNCIL (DEC) COMPRISED OF ALL DIRECTORS WITHIN A DISTRICT. THE RECOMMENDATIONS OF THE DISTRICT EXECUTIVE COUNCIL ARE FORWARDED TO THE VA CENTRAL OFFICE FOR A SERIES OF REVIEWS BY THE REGIONAL DIRECTORS, THE ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR (INCLUDING A REVIEW OF ALL PROFESSIONAL SERVICES INVOLVED), THE CHIEF MEDICAL DIRECTOR, NATIONAL SERVICE ORGANIZATION REPRESENTATIVES, LOCAL CONGRESSIONAL STAFF, AND FINALLY THE ADMINISTRATOR OF VETERANS AFFAIRS FOR APPROVAL AS A PLANNING DOCUMENT.

THE PROPOSED ESTABLISHMENT OF A VAMC IN THE PANHANDLE WAS REMANDED TO MEDICAL DISTRICT 10 AS AN INTEGRAL PART OF THE 1983 MEDICAL DISTRICT INITIATED PLANNING PROCESS (MEDIPP) FOR THE DETERMINATION OF A POTENTIAL SITE. IN THAT PROCESS, OKALOOSA COUNTY FLORIDA WAS IDENTIFIED BASED ON THE INDICES USED IN THE THIRTY YEAR STUDY.

NOWHERE DURING THIS EXTENSIVE ANALYSIS OF SERVICES AND NEEDS FOR SERVICES IN MEDICAL DISTRICT 10 WAS THERE A DETERMINATION OF A NEED FOR A VA MEDICAL CENTER IN MOBILE, ALABAMA.

IN JANUARY, 1984, PROVIDENCE HOSPITAL IN MOBILE, ALABAMA WAS PROPOSED TO THE VA AS A POSSIBLE SITE FOR A VAMC. IN KEEPING WITH OUR PROCESS OF DETERMINING NEEDS, MEDICAL DISTRICT 10 WAS REQUESTED TO STUDY THIS ISSUE DURING THE 1984 MEDIPP PROCESS. THE ISSUE, HOWEVER, WAS NOT THE PURCHASE OF PROVIDENCE HOSPITAL BUT THE NEED FOR THE VA TO ESTABLISH A VAMC IN MOBILE, ALABAMA USING THE SAME INDICES PREVIOUSLY DISCUSSED.

ON JUNE 26, 1984, THE MEDICAL DISTRICT 10 PLANNING BOARD BEGAN ITS REVIEW OF THE MOBILE ISSUE. DURING JULY, 1984, THE CHIEFS OF STAFF COUNCIL SERVED AS A WORK GROUP TO THE DISTRICT PLANNING BOARD AND DEVELOPED A DATA ANALYSIS AND PLANNING DOCUMENT FOR THE PLANNING BOARD BY APPLYING APPROVED AND ACCEPTED DEMOGRAPHIC ANALYSIS TECHNIQUES, UTILIZED BY THE VA IN THE MEDIPP PROCESS. THE DEMOGRAPHICS PROJECTED A VETERAN POPULATION OF OVER 100,000 VETERANS IN THE FLORIDA PANHANDLE WHICH WOULD BE SERVED BY A VAMC LOCATED IN THE PANHANDLE. THOSE DEMOGRAPHICS ALSO PROJECTED APPROXIMATELY 55,000 VETERANS WHO COULD BE SERVED WITHIN A THEORETICAL PRIMARY SERVICE AREA FOR A MEDICAL CENTER IN MOBILE. A SUBSTANTIAL PORTION OF THOSE PROJECTED VETERANS ARE INCLUDED IN THE MORE THAN 90,000 VETERANS CURRENTLY BEING SERVED AT THE VA MEDICAL CENTER, BILOXI, MISSISSIPPI, LOCATED APPROXIMATELY 64 MILES WEST OF MOBILE.

ON AUGUST 2, 1984, THE COMMUNITY ADVISORY COMMITTEE COMPOSED OF 19 REPRESENTATIVES OF STATE VETERAN ORGANIZATIONS, CONGRESSIONAL DISTRICTS, THE MAJOR AFFILIATIONS, AND STATE GOVERNMENT FROM ALABAMA, FLORIDA AND MISSISSIPPI MET IN TUSCALOOSA, ALABAMA FOR THE PURPOSE OF A FULL REVIEW OF THE ENTIRE DISTRICT 10 1984 MEDIPP PLAN. AT THAT MEETING A DELEGATION FROM PROVIDENCE HOSPITAL PRESENTED THE PROPOSAL TO SELL PROVIDENCE HOSPITAL. COMMENTS AND RECOMMENDATIONS WERE INVITED FROM ALL INTERESTED PARTIES RELATIVE TO THE ESTABLISHMENT OF A VAMC IN MOBILE AND ALL ITEMS RECEIVED HAVE BEEN CONSIDERED BY MEDICAL DISTRICT 10 IN THE PROCESS.

THE ENTIRE PACKAGE OF INFORMATION WAS PRESENTED TO THE DISTRICT EXECUTIVE COUNCIL ON SEPTEMBER 13, 1984. AT THAT MEETING, A RECOMMENDATION WAS MADE TO SUSTAIN EXISTING MEDIPP PLANS FOR MEDICAL DISTRICTS 10 AND 12 WHICH PROPOSED A FACILITY IN THE FLORIDA PANHANDLE BY THE YEAR 1990/1991. THE SUPPORTING ANALYSIS SIMPLY DID NOT ESTABLISH THE NEED FOR A VAMC IN MOBILE.

SUBSEQUENT INFORMATION WAS RECEIVED FROM THE AMERICAN LEGION AND THE VETERANS HOSPITAL COMMITTEE OF MOBILE, INCLUDING A STUDY COMMISSIONED BY THAT COMMITTEE BY THE FIRM OF PANNELL, KERR AND FOSTER. NOT UNTIL THAT INFORMATION WAS REVIEWED IN DEPTH WAS A FINAL RECOMMENDATION FORWARDED TO VA CENTRAL OFFICE FROM DISTRICT 10. THAT FINAL MEDICAL DISTRICT RECOMMENDATION AGAIN WAS BASED UPON THE FACT THAT ALL AVAILABLE DATA FAILED TO SUPPORT THE ESTABLISHMENT OF A VAMC IN MOBILE.

CONCERNS SUCH AS THE NEED TO ESTABLISH AN AFFILIATION WITH A MEDICAL SCHOOL AND THE ISSUE OF COST SAVINGS WERE ADDRESSED IN THE REVIEW. FOR THE PAST 20 YEARS, THE VA HAS MADE GREAT STRIDES IN ESTABLISHING AFFILIATIONS WITH MEDICAL SCHOOLS TO THE MUTUAL BENEFIT OF BOTH PARTIES. HOWEVER, THERE IS NO COMMITMENT FOR EVERY VA HOSPITAL TO HAVE AN AFFILIATION. THE RECRUITMENT OF QUALIFIED STAFF IS NOT NECESSARILY HAMPERED WITHOUT SUCH AN AFFILIATION, ALTHOUGH WE RECOGNIZE THE VALUE OF THESE ARRANGEMENTS. OUR CONCERN IS TO PROVIDE HEALTH SERVICES TO THE GREATEST NUMBER OF ELIGIBLE VETERANS IN THE MOST COST EFFECTIVE MANNER. THE FLORIDA STUDY WAS MADE WITHIN THIS CONTEXT AND ASSUMED THAT ANY NEW HOSPITALS WOULD PROVIDE PRIMARY AND SECONDARY CARE WITH TERTIARY LEVEL CARE BEING PROVIDED BY EXISTING FACILITIES ON A REFERRAL BASIS.

THE ADMINISTRATOR HAS RECEIVED EXPRESSIONS OF CONCERN THAT ALL THE INFORMATION PERTINENT TO THIS ISSUE HAS NOT YET BEEN GATHERED. IN RESPONSE, THE ADMINISTRATOR DIRECTED THE DEPARTMENT TO MAKE SURE THAT THE VIEWS OF ALL INTERESTED PARTIES HAD IN FACT BEEN SOLICITED AND TAKEN INTO ACCOUNT. THE DEPARTMENT IS CURRENTLY UNDERTAKING THIS FINAL REVIEW.

OUR MEDIPP PLANNING PROCESS IS OUR BEST MECHANISM FOR CONTINUALLY MEASURING THE SERVICE, RESOURCES AND FACILITIES WE HAVE; WHAT WE NEED TO PROVIDE FOR OUR VETERANS; AND WHAT OPTIONS AND STRATEGIES WE MIGHT SELECT TO MEET OUR CHALLENGES. THIS PLANNING PROCESS HAS BEEN FULLY AND IMPARTIALLY APPLIED TO

THIS ISSUE. WE MUST CONTINUE THROUGH MEDIPP TO MAKE EVERY EFFORT TO DETERMINE HOW WE CAN BEST MEET THE HEALTH CARE NEEDS OF OUR TOTAL VETERAN POPULATION.

THAT CONCLUDES MY REMARKS. THANK YOU FOR YOUR ATTENTION AND THE OPPORTUNITY TO APPEAR.

GOVERNOR GEORGE C. WALLACE

UNITED STATES HOUSE VETERANS AFFAIRS COMMITTEE HEARING

MOBILE, ALABAMA

MARCH 15, 1985

Good Morning, Mr. Chairman, Congressman Shelby, and Congressman Molohan, Congressman Dowdy.

On behalf of all Alabamians, I wish to welcome you to our great State. Not only do the veterans of our great State welcome you, but we all appreciate your coming here to conduct this most important hearing. I come before this Committee, both as Governor and a World War II combat veteran. Today, the beautiful port city, Mobile, is presented with a unique opportunity to provide quality and economical health care to the deserving veterans of South Alabama as well as the Panhandle of Florida. The need for a Veterans Administration Hospital in our area has been with us for many years. The veterans of this region have suffered, and continue to suffer, because of the lack of highly specialized and comprehensive medical care available to them. When Providence Hospital became available to the Veterans Administration, approximately a year ago, a once in a lifetime opportunity presented itself whereby the VA could purchase an existing hospital in excellent condition

at a minimal cost. Mr. Chairman, the cost is twenty-five cents on the dollar based on 1985 new construction dollars. In addition to providing for 349 acute care hospital beds, Providence would also provide a 126 bed nursing home unit. According to a recent Veterans Administration hospital study, entitled "Caring for the Elderly Veteran", the nursing home unit alone would cost $6.5 million to construct and if the Providence proposal is accepted, it will be given to the Veterans Administration within the $24 million purchase price. Alabama needs you, and most importantly, her veterans need you. The time to act is now. South Alabama's economy and population is rapidly expanding. With the Tennessee-Tombigbee Waterway recently opening, and large reserves of natural gas having been discovered off Alabama's shores, our aging veteran population into the year 2000 will more than double. Mr. Chairman, if this fiscally responsible opportunity to assist our veterans is lost, I'm afraid that it will never be presented again. In my opinion, this conversion endeavor will be applauded by all Americans while serving as a pilot project for the Veterans Administration and other governmental agencies regarding future creation of medical care facilities.

Mr. Chairman, America owes a great debt of gratitude to our veterans who have honorably and faithfully served in the armed forces during our country's time of need. Alabama, in particular, has always led the way in America's volunteer forces during periods of war. Now is the time to recognize the tremendous needs of the veterans in this area by supporting this worthy endeavor to convert Providence Hospital into a VA Medical Center.

I am personally committed to this project and my office stands ready to assist this distinguished Committee in whatever way necessary in seeing this wonderful opportunity become a reality.

Thank you.

STATEMENT OF DEAN PITTMAN AT THE HEARING ON LOCATION OF
VA MEDICAL CENTER - FRIDAY, MARCH 15, 1985

I APPRECIATE THE INVITATION BY CONGRESSMAN SHELBY TO ATTEND THIS HEARING AND THE OPPORTUNITY TO COMMENT ON THE PROPOSED SITE FOR THE VA MEDICAL CENTER.

I AM DEAN OF THE UNIVERSITY OF ALABAMA SCHOOL OF MEDICINE, UAB, AND HAVE BEEN ASSOCIATED WITH THE VETERANS ADMINISTRATION DEPARTMENT OF MEDICINE AND SURGERY FROM 1957 TO THE PRESENT. I WAS CHIEF OF THE NUCLEAR MEDICINE SERVICE AT THE BIRMINGHAM VA MEDICAL CENTER FROM 1958 TO 1971. FROM 1971 TO 1973 I WAS ASSISTANT CHIEF MEDICAL DIRECTOR FOR RESEARCH AND EDUCATION AT THE VA CENTRAL OFFICE, WASHINGTON, D.C. I HAVE BEEN DEAN OF THE SCHOOL OF MEDICINE SINCE 1973.

I HAVE NOT HAD AN OPPORTUNITY TO REVIEW THE PERTINENT DEMOGRAPHICS RELATIVE TO THE PROPOSED SITE: AND, THEREFORE, I AM NOT AWARE OF THE INDICATED NEED FOR VETERANS' MEDICAL SERVICES IN THIS PRIMARY SERVICE AREA. HOWEVER, IT WOULD APPEAR, ON THE BASIS OF GENERAL FACTORS, THAT THERE IS A SIGNIFICANT POOL OF VETERANS WHO LIVE IN THE MOBILE AND ADJACENT AREAS AND MUST TRAVEL CONSIDERABLE DISTANCES TO AVAIL THEMSELVES OF MEDICAL CARE AT A VA MEDICAL CENTER.

THE CLOSEST PRIMARY CARE AND SECONDARY CARE FACILITIES ARE LOCATED IN MONTGOMERY, 176 MILES TO THE NORTH, AND BILOXI, 60 MILES TO THE WEST. THE CLOSEST TERTIARY CARE FACILITIES ARE LOCATED IN BIRMINGHAM, ALABAMA, 270 MILES TO THE NORTHEAST; GAINESVILLE, FLORIDA, 400 MILES TO THE EAST; NEW ORLEANS, LOUISIANA, 145 MILES TO THE WEST; AND JACKSON, MISSISSIPPI, 185 MILES TO THE NORTHWEST.

IF THE DATA RELATIVE TO VETERANS IN THIS AREA INDICATE A NEED FOR A TERTIARY CARE FACILITY IN THE SOUTHERN ALABAMA/NORTHERN FLORIDA AREA, IT SHOULD BE, IN MY JUDGMENT, LOCATED IN MOBILE SINCE THIS IS THE ONLY LOCALE IN THE REGION WITH AN LCME ACCREDITED SCHOOL OF MEDICINE. LET ME GIVE YOU A BRIEF HISTORY OF MEDICAL CARE IN THE VA DEPARTMENT OF MEDICINE AND SURGERY AND MY REASON FOR MAKING SUCH A STATEMENT:

IN 1946, A PROGRAM WITHOUT PRECEDENT IN THE HISTORY OF PATIENT CARE IN THIS COUNTRY WAS INITIATED IN THE VA HOSPITAL SYSTEM BY GENERAL PAUL HAWLEY AND DR. PAUL MAGNUSON. DR. HAWLEY WAS THE FIRST CHIEF MEDICAL DIRECTOR OF THE VA DEPARTMENT OF MEDICINE AND SURGERY AFTER WORLD WAR II, AND DR. MAGNUSON WAS ON HIS STAFF.

THIS NEW PROGRAM WAS INITIATED BY VA POLICY MEMORANDUM NO. 2 DATED JANUARY 30, 1946[1]. THIS MEMORANDUM IS A PROMINENT PART OF MEDICAL HISTORY IN THIS COUNTRY AND CONTINUES IN EFFECT TO THIS DATE. WITHIN A SHORT PERIOD AND UPON DR. HAWLEY'S RETIREMENT, DR. MAGNUSON BECAME CHIEF MEDICAL DIRECTOR AND PERSONALLY CARRIED THE MAJOR RESPONSIBILITY OF IMPLEMENTING THE POLICIES AND PROCEDURES THROUGHOUT THE VA HOSPITAL SYSTEM. THE PROGRAM IS KNOWN AS THE AFFILIATED PROGRAM BETWEEN THE VA MEDICAL CENTERS AND MEDICAL SCHOOLS IN THIS COUNTRY.

THE HISTORY OF MEDICAL CARE IN THE VETERANS ADMINISTRATION TELLS THE STORY VIVIDLY. PRIOR TO AFFILIATION WITH THE NATION'S MEDICAL SCHOOLS, IT WAS EXTREMELY DIFFICULT, IF NOT IMPOSSIBLE IN MOST HOSPITALS, TO RECRUIT PHYSICIANS INTERESTED IN OTHER THAN GENERAL PRACTICE WITH THE VETERANS ADMINISTRATION DEPARTMENT OF MEDICINE AND SURGERY. THIS ARRANGEMENT GENERALLY PRECLUDED THE VA HOSPITAL SYSTEM FROM DELIVERING ANYTHING BUT PRIMARY OR SECONDARY MEDICAL CARE, AND THE QUALITY OF THAT CARE PRIOR TO 1946 WAS REPORTED TO BE INFERIOR TO THAT RECEIVED BY THOSE ABLE TO PURCHASE PRIVATE MEDICAL CARE[2].

SOME OF YOU MAY RECALL THE NATIONWIDE ADVERSE PUBLICITY GIVEN VA HOSPITALS BY THE MEDIA AT THE END OF WW II. UNDER THE PROGRAM OF AFFILIATING VA MEDICAL CENTERS WITH SCHOOLS OF MEDICINE, A VERY HIGH QUALITY HEALTH CARE SYSTEM, IN MANY CASES EQUAL TO OR EVEN SUPERIOR IN SOME CASES TO OTHER SYSTEMS IN THE COUNTRY, HAS EVOLVED AND NOW EXISTS IN OUR VA MEDICAL CENTERS. AN EXCELLENT EXAMPLE SUPPORTING THIS STATEMENT WAS THE DEVELOPMENT OF THE CARDIOVASCULAR SURGICAL PROGRAM AT THE VA MEDICAL CENTER IN BIRMINGHAM BY

DR. JOHN KIRKLIN WHICH RESULTED FOR A CONSIDERABLE PERIOD OF TIME IN THE BIRMINGHAM VA MEDICAL CENTER'S BECOMING THE REFERRAL HOSPITAL FOR VETERAN PATIENTS THROUGHOUT THE NATION NEEDING THIS SERVICE.

ANOTHER EXAMPLE IS THE KIDNEY TRANSPLANT PROGRAM ESTABLISHED IN THE BIRMINGHAM VA MEDICAL CENTER BY DR. GIL DIETHELM IN WHICH THE FIRST KIDNEY TRANSPLANT IN THE STATE OF ALABAMA WAS PERFORMED ON A SERVICE-CONNECTED VETERAN FROM COTTONDALE, ALABAMA. THIS VETERAN WAS A BULLDOZER OPERATOR AND LIVED A HEALTHY NORMAL LIFE FOR TEN YEARS AFTER HIS TRANSPLANT. HE DIED OF A HEART ATTACK, WHILE HIS KIDNEYS WERE STILL FUNCTIONING NORMALLY.

MY POINT IS THIS. I SINCERELY BELIEVE, AFTER CONSIDERING ALL FACTORS INVOLVED, PARTICULARLY QUALITY PATIENT CARE, IF THERE IS A NEED FOR A TERTIARY CARE VA MEDICAL CENTER IN THIS AREA OF THE COUNTRY, MOBILE, ALABAMA, IS THE ONLY PLACE HAVING THE REQUIRED FACILITIES, RESOURCES AND ENVIRONMENT ESSENTIAL TO PROVIDING THE BEST POSSIBLE MEDICAL CARE TO OUR VETERAN SERVICEMEN AND WOMEN.

I HAVE BROUGHT WITH ME FOR DISTRIBUTION, TO THOSE OF YOU WHO WISH COPIES, A SUPPLY OF THREE DOCUMENTS SUPPORTING MY STATEMENTS IN CONSIDERABLE DETAIL. ONE IS THE MINUTES OF MY FIRST VA DEAN'S COMMITTEE MEETING OF JULY 30, 1973, AFTER I ASSUMED THE POSITION OF DEAN[3]; ANOTHER IS THE STATEMENT THAT I MADE TO THE COMMITTEE ON VETERANS' AFFAIRS OF THE U.S. SENATE ON October 17, 1977[4]; AND THE THIRD IS POLICY MEMORANDUM NO. 2. THESE THREE DOCUMENTS GO INTO COMPLETE DETAIL WHICH SUPPORT THE STATEMENTS THAT I HAVE GIVEN THIS MORNING.

THANK YOU FOR THE OPPORTUNITY TO EXPRESS MY VIEWS ON THIS SUBJECT.

(1) POLICY MEMORANDUM NO. 2

(2) LEWIS, BENJAMIN, PH.D.:

(3) DEAN'S COMMITTEE MEETING, 7-30-73

(4) STATEMENT TO COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE, 10-17-77

COPY

POLICY MEMORANDUM NO. 2 January 30, 1946

SUBJECT: Policy in Association of Veterans' Hospitals with Medical Schools

1. GENERAL CONSIDERATIONS: a. Necessity for Mutual Understanding and Cooperation. The Department of Medicine and Surgery of the Veterans' Administration is embarking upon a program that is without precedent in the history of Federal hospitalization. It would, therefore, be most unusual if numerous problems did not arise for which no fully satisfactory solution were immediately apparent. Such problems frequently can be solved only by trial and error; and, until workable solutions are found, both parties in the program must exercise tolerance if the program is not to fail.

There can be no doubt of the good faith of both parties. The schools of medicine and other teaching centers are cooperating with the three-fold purpose of giving the veteran the highest quality of medical care, of affording the medical veteran the opportunity for post-graduate study which he was compelled to forego in serving his country, and of raising generally the standard of medical practice in the United States by the expression of facilities for graduate education.

The purpose of the Veterans' Administration is simple: affording the veteran a much higher standard of medical care than could be given him with a wholly fulltime medical service.

The purposes of both parties being unselfish, and there being no conflict of objectives, there can be no serious disagreement over methods. It will be recognized that the Veterans' Administration is charged with certain legal responsibilities in connection with the medical care of veteran which it cannot delegate, if it would. Yet the discharge of these responsibilities need not interfere with the exercise by the schools of their prerogatives in the field of education.

All medical authorities of the Veterans' Administration will cooperate fully at all times with the representatives of associated schools and other centers. It is the earnest desire of the Acting Chief Medical Director that our relations with our colleagues be cordial as well as productive.

b. General Division of Responsibility: The Veterans' Administration retains full responsibility for the care of patients, including professional treatment, and the school of medicine accepts responsibility for all graduate education and training.

2. THE VETERANS ADMINISTRATION:

a. Operates and administers the hospital.

b. As rapidly as fully qualified men can be had, will furnish

full-time chiefs of all services (see paragraph 5 below) who will supervise and direct the work of their respective staffs, including the part-time attending staff furnished from the School of Medicine, insofar as the professional care of patients is concerned. Nominations by Deans' Committees for such full-time positions will be welcomed; and, unless there be impelling reasons to the contrary, will be approved wherever vacancies exist. These service chiefs are fully responsible to their immediate superior in the Veterans Administration..

c. Appoint the consultants, the part-time attending staff and the residents nominated by the Deans' Committee and approved by the Veterans Administration.

d. Cooperate fully with the Schools of Medicine in the graduate education and training program.

3. THE SCHOOLS OF MEDICINE:

a. Will organize a Deans' Committee, composed of senior faculty members from all schools cooperating in each project, whether or not furnishing any of the attending or resident staff.

b. Will nominate an attending staff of diplomats of specialty boards in the numbers and qualifications agreed upon by the Deans' Committee and the Veterans Administration (See 6e).

c. Will nominate, from applicants, the residents for graduate education and training.

d. Will supervise and direct, through the Manager of the hospital and the Consultants, the training of residents.

e. Will nominate the consultants for appointment by the Veterans' Administration.

4. HOSPITAL MANAGERS:

a. are fully responsible for the operation of their hospitals.

b. Will cooperate with the Deans' Committee, bringing to its attention any dereliction of duty on the part of any of its nominees.

5. CHIEFS OF SERVICE:

a. Are responsible to their superior in the Veterans Administration

for the conduct of their services.

b. Will bring to the attention of their superior, for his action, such cases as they are unable to deal with personally of dereliction of duty or incompetence on the part of any full-time or part-time staffs under their control.

c. Will, together with the part-time attending staff, under direction of the Manager, supervise the education and training program.

d. When full-time employees of the Veterans Administration, will be diplomats of their respective boards and will be acceptable to the Deans' Committee and to the specialty boards concerned. It is the urgent purpose of the Veterans Administration to place full-time fully qualified and certified chiefs of service for all services in each hospital associated with a School of Medicine. Except in cases where the chief selected has local affiliations, which might embarrass or prejudice his relations with one or another of the associated schools, his initial assignment may not be cleared through the Deans Committee. In all cases, when it has been conclusively demonstrated that a chief of service cannot cooperate with a Deans Committee, he will be transferred (if efficient otherwise) and replaced by another.

Until this purpose can be fully accomplished, however, in order that a hospital may obtain approval for resident training by one or another specialty board, it may be necessary to appoint part-time chiefs of services who meet the requirements of the boards. This will be done; but it will be done with the understanding that the part-time chiefs will be replaced with qualified full-time chiefs as rapidly as they become available. The duties and responsibilities of part-time chiefs will be the same as those of full-time chiefs.

6. PART TIME ATTENDING STAFF:

a. Will be responsible to the respective chiefs of service.

b. Will accept full responsibility for the proper care and treatment of patients in their charge.

c. Will give adequate training to residents assigned to their service.

d. Will be veterans unless approval in each case has been given by the Chief Medical Director.

e. Will be diplomats of their respective boards and acceptable to such boards for direction of resident training. Exception may be made in the case of a veteran who has completed the first part of his board examination, but whose completion of the examination was interrupted by the exigencies of the military service.

f. Will hold faculty appointments in one or another of the associated Schools of Medicine, or will be outstanding members of the profession of the caliber of faculty members.

7. CONSULTANTS:

a. Will be Veterans unless approval in each case has been given by the Chief Medical Director.

b. Will be members of the faculty, or professional rank, of one or another of the associated Schools of Medicine.

c. Will, as representatives of the Schools of Medicine, direct and be responsible for the educational training of residents.

d. Will afford to the Manager and the proper Chief of Service the benefit of their professional experience and counsel.

e. Will conduct their duties through, and in cooperation with, the Manager and the proper Chief of Service, and also, in matters of education and training, with the part-time Attending Staff -- always, however, coordinating with the Chief of Service.

Ala. J. Med. Sci., Vol. 10, No. 3, 1973,
pp. 349-358

MINUTES
VA DEANS COMMITTEE

A regular meeting of the Birmingham VA Deans Committee was held in the Director's Conference Room, VA Hospital, on Monday, July 30, 1973, at 2:30 p.m.

There were present:

Dr. James A. Pittman, Jr., Chairman presiding
Dr. S. Richardson Hill, Jr.
Dr. J. Durwood Bradley
Dr. David M. Witten
Dr. Keith D. Blayney
Mr. C. G. Cox
Dr. Joaquin S. Aldrete
Dr. Guenter Corssen
Dr. Francisco A. Gutierrez
Dr. P. H. Linton
Dr. Arnold G. Diethelm (Representing Dr. John W. Kirklin)
Dr. Thomas W. Sheehy
Dr. Marie L. O'Koren
Dr. Daniel T. Meadows (Representing Dr. C. A. McCallum, Jr.)
Mr. James E. Moon
Dr. Ralph Z. Levene
Dr. William F. Bridgers
Dr. C. H. Lupton
Dr. C. H. Winkler
Dr. Jeffrey T. Keller (Representing Dr. Henry B. Peters)
Dr. Eoline I. McGowan (Representing Dr. John W. Foltz)
Mr. Elliott Wells
Mr. Joseph D'Angelo

Absent:

Dr. Robert P. Glaze
Dr. John M. Miller, III
Dr. Robert E. Roth
President, Housestaff Council

Introduction

The following were introduced by the Chairman: Dr. Joaquin S. Aldrete, VA Chief of Staff, member; Dr. Thomas W. Sheehy, Interim Chairman, Department of Medicine, member; Dr. Ralph Z. Levene, Chairman, Department of Opthalmology, member; and Mr. Elliott H. Wells, Director, Administration and Fiscal Affairs, UAB.

VA—Academic Relations

The following opening statement was made by Dr. James A. Pittman, Jr., Chairman:

"Mr. Cox, Ladies and Gentlemen: I wanted to make a statement in a more formal manner than is perhaps usual at these meetings in order to get this medical school and medical center administration on record as strongly supporting the mission of the VA in general and of this VA hospital in particular in providing medical benefits to which the nation's veterans and the veterans of this area are morally and legally entitled. Specifically, the present administration of the Medical Center recognizes and supports the following:

"Provision of service *to* the government of the United States by an individual, on either a voluntary or a mandatory basis, entitles the veteran to special benefits from the Government, including special medical care. This principle is accepted by most countries and has been evident among English-speaking peoples at least since the veterans laws passed by the British Parliament shortly after the battle with Spanish Armada of 1588.

"Affiliation of VA medical facilities with schools of medicine and other academic institutions is assumed to improve the *quality* of medical care - or 'health care,' if you prefer that term - delivered to the veteran by those facilities and their staffs. The schools of this Medical Center will strive to justify this assumption and to do so in as documentable a fashion as possible.

"To this end, we will work together with the VA to recruit and retain the most highly qualified staff possible and to maintain their knowledge and skills at a high level of competence by an emphasis on continuing education.

"In addition, the UAB recognizes and accepts its responsibility, as staged in formal affiliation agreements and in VA documents, for the organization and quality of the education programs in the VA. We also take cognizance of the intent of federal law to utilize the VA as a major training facility for the production of health manpower for the nation and of the major contributions now being made by the VA in this respect. For example, more than half the nation's medical students now receive at least part of their training in the VA; about one-third of the country's residents do so; and 102 VA hospitals are presently affiliated with 90 of the 112 medical schools. In addition, VA hospitals maintain some 1,800 affiliations with other schools of the health professions. The stated position of the VA in all these training programs is that the VA provides the facilities and most or all of the funding, while the schools take the responsibility for the organization and quality of the programs. As put so exactly by Dr. Benjamin Lewis, one should think of 'the daily joint activities of many of these hospitals and medical schools as representing a single entity with a life span of its own - a simultaneous enricher of both government and higher education.' Keeping this perception of the relation and the regulations to which both parties are subject in mind should minimize misunderstandings, paranoia and suspicions on the part of both the schools and the VA.

"The UAB administration also recognizes the legal constraints within which the VA must operate and will, in addition to supporting the VA in its adherence to the law, strive to educate its faculty and staff in these matters and assist them in understanding and abiding by such regulations.

"As stated above in the third paragraph, we recognize the present and growing importance of continuing education for the staff and will strive to provide this for the VA staff in this area. I commend for your reading what seems to me a classic memorandum on this subject by Dr. Laurence V. Foye, Jr., Director, Education Service, VA Central Office. The passage and signing into law of PL 92-541 gave added stimulus to VA participation in continuing education education with its encouragement to establish Regional Medical Education Centers (or 'RMECs') around the country. Dr. S. R. Hill has already written to VA Central Office to invite the VA to place an RMEC here at this VA facility to fulfill the intent of the law. In addition, Mr. Carl Engquist and Mr. Joe D'Angelo of the VA staff and Dr. Margaret Klapper, Associate Dean for Continuing Education, have taken to Central Office a preliminary proposal for such a center. We agree with the present philosophy of Central Office Education Service that this is 'the wave of the future' in medical education, and we shall try hard to participate heavily in it and to support strongly the VA in its work in continuing education.

"We recognize the dual function of funds for medical and related research in the VA, and we shall endeavor to see that the funds are used for both (a) recruitment and retention of highly qualified staff and (b) generation of new knowledge. As with education, biomedical research has over the past two de-

cades become the legal charge and responsibility of the VA.

"Regionalization and other changes in the patterns of medical education and practice are seen as inevitable. We strongly support the VA's efforts in this direction and will work to implement regionalization in Medical District #14. Listed in the discussion to follow are some reasons to think that we can do a particularly effective job of regionalizing our resources in Alabama. From the UAB's viewpoint, the VA provides a unique vehicle for coordinating our educational efforts to the ultimate benefit of non-veteran citizens of Alabama as well as veterans.

"Patterns are changing not only in geographic distribution of resources but also in manpower utilization. The UAB has an unusual concentration of schools of health professions (medicine, dentistry, nursing, allied health, optometry, with pharmacy at nearby Samford University) as well as an array of specialized facilities (eye hospital, diabetes hospital, children's hospital, etc.). 'The health care team' has become a commonplace phrase, and 'training together' an oft-stated goal. In the present milieu, the patient tends to become submerged in a scramble for territory, control, prestige and - especially - the dollar. In my estimation, this will resolve itself into a *battle between cost and quality*, using the latter in its broadest sense to include accessibility. Though neither will be easy, the *cost* will be more easily measured than the *quality*.

"A recent issue of *The Lancet* stated it this way: 'The U.K. must seek to secure full value for every pound devoted to health. In the general hospital, must patient A really spend that extra twenty-four hours in the intensive-care unit; must patient B occupy a fully staffed bed, or could he equally well be investigated or treated in simple overnight accommodation, as a day patient or an outpatient; will patient C gain from a hospital visit any more than from non-hospital care? Answers to these questions are being sought with growing persistence. Owing to this and to changes in the nature and treatment of illness, the demand on hospitals is altering: the growth areas are the intensive-care and other highly specialized inpatient units, and the outpatient department with its associated investigative resources . . . . Outside hospital practice should be governed by two precepts. The first is that no patient should take up a doctor's time when he can equally well be treated by someone with a less elaborate training. The second (not necessarily incompatible with the first) is that patients should have prompt access to doctors when they need, or think they need, medical attention. The aim should be to avoid wasteful use of physical and human resources.' As I said, a battle between cost and quality.

"We are all in this together, and the UAB will try to help work out the problems while at the same time looking to the VA for guidance, advice and resources in doing so.

"*Patient care* is recognized as the *primary* responsibility of the Veterans Administration Department of Medicine and Surgery. While *education* is the main function of the schools in the UAB Medical Center, and while biomedical *research* is an obligation of both the VA and the schools (and we think an essential component in achieving quality patient care and medical education), we must not forget that the VA Department of Medicine and Surgery exists *primarily* for the care of the sick veteran and *not* for education or research and, certainly, not as has sometimes been asserted, 'for the medical schools.' Failure to appreciate this essential difference in goals and orientation has been responsible for many disagreements and misunderstandings in the past.

"So recognition of the above nine points forms the basis of at least part of our commitment - that of the administra-

tion of the UAB - to work with the VA in achieving the latter's goals:

"1) The historic, moral and legal basis for providing medical care to veterans.

"2) The original underlying reason for affiliations of VA health care units with schools - to upgrade the quality of care.

"3) The accomplishment of this primarily by recruitment and retention of highly qualified staff, a joint responsibility.

"4) Responsibility of the UAB for the organization and quality of educational programs in the VA hospitals in this medical district.

"5) The legal constraints under which the VA must operate.

"6) The importance of continuing education.

"7) The dual function of research funds in the VA - staff recruiting and generation of new knowledge.

"8) The importance of regionalization and changing patterns of medical education and practice.

"9) The primacy of high quality *patient care* as the goal of the VA Department of Medicine and Surgery.

"We in Birmingham are in a good - if not unique - position to help the VA carry out its responsibilities and at the same time help the UAB accomplish its goals. And we can do so in a symbiotic, not a parasitic, way from the point of view of either the VA or the UAB. I myself have had almost 18 years of federal service, most of it in the VA. And, as you know, I've just completed two years in VA Central Office in Washington, where I was intimately exposed to the goals and aspirations of the staffs that work there, as well as the traditions and laws of the VA. But I'm just a boy in my understanding of the VA as compared with Elliott H. Wells, now Director of Administration and Fiscal Affairs at the UAB School of Medicine, formerly Director of the Budget Staff of the Department of Medicine and Surgery in Central Office. Mr. Wells has 33 years of federal service, 27 years of which were in the VA, and most of these were in Central Office. Mr. Wells' position as Director of the Budget Staff provided him with a uniquely general view of VA operations, and he is certainly my main contribution to the affiliation here in Birmingham! His main problem to date is scaling down his terminology and scope of thinking, his last budget having been $2.7 *billion*.

"However, there are many other people on the staffs here who can appreciate both sides of the street. Mr. Cox, the Hospital Director, is Associate Professor in the Department of Public Health and Epidemiology, Assistant Professor in the Department of Community Dentistry, and Adjunct Assistant Professor in the Graduate Program in Hospital and Health Administration. Dr. S. R. Hill, Jr., Vice President for Health Affairs, originally came to Birmingham as a full-time employee of the VA and has recently served on the main advisory body for the VA, the Special Medical Advisory Group, or 'SMAG.' Dr. Joseph F. Volker, President of UAB, has served on the Career Development Committee and other committees for the VA. Dr. Tinsley R. Harrison was the second Distinguished Physician named in the VA and is currently the senior member of this group of ten outstanding clinicians. Dr. Walter B. Frommeyer, currently Distinguished Professor of the UAB and President of the American College of Physicians, was the first Chief of Medicine at this VA Hospital when it opened in 1953. Dr. T. Joseph Reeves, renown cardiologist, Professor of Medicine here, and recently Chairman of the Department of Medicine, was later Chief of Medicine at this VA Hospital. Dr. Thomas W. Sheehy, currently Acting Chairman of the Department of Medicine, has been Chief of Medicine here for three years.

"I believe that every single member of the clinical full-time faculty of the medical school also holds a clinical appointment in

the VA, most often 'WOC,' without compensation. If not, we should have it soon, since it is a worthy goal to have the full talents of the medical school faculty available to the VA, and fully available (e.g., to examine patients and sign orders). For example, Dr. John W. Kirklin, Charles and Fay Kerner Professor of Surgery and Chairman of the Department, has recently taken the responsibility for running one of the four surgical wards in the hospital - and he really runs it: it's not tokenism.

"In the other direction, all the clinical staff at the VA Hospital hold appointments on the faculty of the medical school or other schools of the UAB. Presumably, this upgrades the quality of the staff of the VA.

"In addition to the closeness - or the unity - of our staffs, we have an absolutely unique physical connection between the VA Hospital, medical and dental research buildings, and the University Hospital. There are three other VA hospitals in the country which are physically joined to medical school facilities or soon will become joined. But in each of these cases the connection is by a ramp, bridge or tunnel. In no other instance is the connection a major building, as it is here.

"As the medical center has grown, it has done so in such a manner that the VA Hospital now finds itself even more in the middle of medical activities. It is now surrounded by the University of Alabama Hospitals and Clinics, the Lyons-Harrison Research Building, the Zeigler Building, the Dental School, the administration activities in Mortimer Jordan Hall, the Eye Foundation Hospital, the School of Optometry, the Medical Center Library, the New Basic Sciences Building, the Nursing School dormitory, the Regional Technical Institute of the School of Community and Allied Health Resources, the Center for Developmental and Learning Disorders (which has more to offer the VA than might be apparent from the name; e.g., in audiology and speech pathology), the Ambulatory Center, and many other units.

"In addition to the strictly local geography, VA's Medical District #14 is uniquely 'clean' in its relations. If one looks over a map of VA installations throughout the U.S., no other place can really match us in this respect. Only the states of Washington and Iowa come close, and they have complicating factors we don't have. Even the establishment of the medical school in Mobile fails to muddy the water, because of the distances involved, the good relations between our two schools, and the likelihood that a VA outpatient clinic will be established in Mobile in the near future - a possibility that we strongly support.

"One of the most discouraging and 'cynicising' sights one beholds in present day Washington is the steady flow of supplicants coming to Central Office, cup in hand, for a dole to keep the medical school afloat. We want to avoid that position and image. And with the remarkable staff, facilities, physical and geographical assets we now have, we certainly can. The VA has played an integral, essential part in the building of this medical center, and it continues to do so to the tune of some $24 million annually and the contribution of new initiatives in health care education and delivery. Without the VA, education and research in this Medical Center would be dismally and probably permanently impaired. But, without the schools, the VA, particularly with its present pay scales, would probably be able to offer only second- or third-rate patient care, if that. And it would be almost totally unable to provide education or research.

"Our overall goal, therefore, is to make this a truly symbiotic relation, to the advantage of all, *especially the patient.*"

Changes in Appointment Procedures for Residents and Interns

Mr. D'Angelo explained the changes from the previous test plan "E" procedure for appointing and paying residents and interns, under which their salaries were prorated evenly throughout the year, to the regular plan, under which residents and interns receive pay only for the time they are actually working in the hospital.

One of the problems caused by the regular system is the fluctuation of salaries from month to month. To fully inform each resident and intern, Mr. D'Angelo prepared a schedule showing the pay days, the source of income and the gross amount. An example was distributed to the committee members along with other informational data for all to review. Information to each resident and intern has also been distributed with data in detail regarding their fringe benefits. This includes instructions for contacting any bank to have Blue Cross insurance payments deducted and automatically submitted to the University. While a resident is in a pay status at the VA, he cannot receive fringe benefits from the University; therefore, Central Office has allowed the VA to increase their annual salary by $200.00. Now the residents and interns buy their fringe benefits while at the VA from the University. The $200.00 is on a pro rata basis—if a doctor is here only six months, he would receive only $100.00. It was emphasized that VA schedules for the housestaff should not be changed; otherwise, this could result in a resident being without insurance benefits.

Time cards have been sent to department chiefs for certification of accuracy at the end of each pay period. Should a time card be signed but the resident was actually not on duty and with no indication to this effect, the certifying official must be held liable.

The VA in the past has, and will continue in the future, permitted the residents to rotate through non-VA institutions and remain in a pay status, up to one-sixth of the resident's time. This policy permits training in areas not available in the VA. For example, if a resident is scheduled for twelve months at the VA, he can be assigned to a non-VA hospital up to two months as an elective. On examination of the proposed schedules for fiscal year 1974, it was discovered that some schedules would have exceeded the one-sixth allowance. Adjustments were necessary and have been made.

There will be a new vacation policy, and the VA will match the leave plan to that of the University, with a proportionate share for the time the residents are in the VA system.

At this point, Dr. Hill inquired if the President signs the new bill on Wednesday if we would be able to contract with the University. (The bill was signed by the President at approximately noon on Thursday, August 2, 1973.) Dr. Pittman explained the mechanism under which this could be done, but it was agreed, assuming it becomes law, that in all likelihood it could not be placed into effect until regulations are published, which might take several months.

In making the changes from Plan "E" to the regular system, members of the Housestaff Council participated extensively and were very helpful in gaining the understanding and support of all the residents and interns. A tremendous amount of detailed work went into this change, and without the VA educational staff working closely with the Housestaff Council many problems and misunderstandings no doubt would have occurred.

Approval for Expanded Neurological Ward

Background information was supplied by Mr. Cox. Central Office approved the elimination of our 41 psychiatric beds, which occupied the eighth floor, with the transfer of total inpatient responsibilities to the Tuscaloosa VA Hospital under our regionalization concepts. At that time, there was great demand for surgical beds, and the decision was made that 41 additional surgical beds would replace the psychiatric beds. The new surgical beds were placed on ward 8-South, in accordance with VA space criteria. Approximately 40 per cent of the space on the eighth floor remains unassigned. There is a strong feeling within the three other VA hospitals in VA Medical District #14 that a Neurological Service can only be established in this hospital, and the Executive Council has gone

on record recommending our present sixteen neurological beds be supplemented with the additional beds that can be placed on ward 8-North. This would make a total of approximately 35 beds. The Regional Medical Director, Dr. R. M. Whittington, visited the hospital, studied the space and suggested that we apply to the VA Central Office for expanded neurological services. It is desired to have the support and formal approval of the Deans Committee for this proposal.

Dr. Sheehy concurred in the real need for neurological services in VAMED #14, stating there is no other service in this medical district. However, he cautioned about the Neurological Service becoming independent because of the care rendered on that service in the VA. He added that the care has not been good in case after case, and one must look at the type personnel working in that area. Dr. Bradley agreed with Dr. Sheehy's thoughts that someone would need to supervise general medicine care, or employ first-rate individuals. He stated we should be careful to make sure we have adequate staff to take care of these terribly ill patients, some of whom have had cerebral vascular accidents, and he viewed this as a very serious undertaking.

Dr. Pittman reminded the committee that there was considerable pressure here to separate Neurology from the Department of Medicine, and in this connection he believed this was supported by Dr. Reeves, Dr. Hill and Dr. Meador. This came to Dr. Pittman's attention while he was still in Washington. At that time, he asked Dr. Warren Huber, Director, VA Neurology Service, to check the organization of Neurology throughout the country in medical school settings. He found that over the past four or five years these former divisions of Medicine, or other specialties, such as Psychiatry, have been moving out into a more autonomous status, usually as departments themselves. Because of this, and because of the general agreement here, Neurology has been made an independent department with Dr. James H. Halsey, Jr., as Acting Chairman. The VA has also changed the organization of VA hospitals to make Neurology a separate service reporting to the Chief of Staff in lieu of a section of Medicine.

During the discussion, the problems of patient care came up, and Dr. Pittman agreed that 35 beds sound like quite a large number. He added, however, that this would be a resource to use for attracting additional staff, and there is salary support for an additional neurologist. Mr. Cox confirmed this. In addition to the two physicians paid by the VA, there will be three residents, an increase of two. Dr. Aldrete shared Dr. Sheehy's apprehension about initiating the service without significant changes in this hospital. Dr. Sheehy pointed out that medical students do not have to intern any more and go right into this subspecialty, and their training is not very deep in general medicine. The patients, however, have combined problems.

The matter of funding an expanded Neurology Service was discussed. If we did obtain Central Office approval, recurring funds would generally come to the hospital to support the additional authorized beds. It would place this hospital in a position of having over 500 operating beds.

Mr. Wells, former VA Budget Staff Director, explained that in the fiscal year 1974 budget for medical care the actual employment levels, in spite of rumors, were reduced over 1973 levels because of activation of new hospitals, which took $52 million out of the existing system. This is what concerns many about getting additional staffing to increase from 16 to 35. It was estimated, if approximately 20 additional beds were approved, it would equate to $1½ million recurring funds on the basis of VA criteria of funding new beds.

After further discussion, it was the general consensus that we would be missing an opportunity not to apply for approval, with the understanding that it would take dollar support to staff it. All agreed the need is here, but by waiting we could jeopardize our chances. It was thought if Dr. Halsey could recruit additional help things would improve.

The motion was made by Dr. Sheehy that we request the additional neurological beds with proper funding and staff, emphasizing the need to implement this as soon as possible because of the urgent need in VAMED #14. He also asked that Dr. Halsey pursue full and adequate staffing. Further, he would have to recruit a neurologist to be chief at the VA, and strong efforts would have to be made to greatly improve the residency program, which until now has not been up to the standards of other services in the past. The motion was seconded by Dr. Hill and unanimously carried.

S-9048

An excerpt from a recent Legislative Report on the proposed legislation (S-59), now on the President's desk, was distributed to all present. This bill does not contain some of the inflationary provisions that were in S-10880 and responsible for the presidential veto this past November. Dr. Pittman, in discussing the changes, stated it contains virtually the same language as the VA regulation published in 1970 that restricted the time and place VA employees could be paid. This restriction was found by many to be inflammatory at the time, and it required physicians to spend the actual time in the VA hospital for which they were paid. This will now become Federal law. Among other provisions, the VA will be able to pay nurses night differential, and the Administrator of Veterans Affairs will be authorized to enter into contracts with university schools of medicine and dentistry for housestaff coverage.

New Admission Policies, Procedures and Facilities

This matter was discussed by Dr. Aldrete who stated the outpatient services in this hospital, as well as most VA hospitals, have been somewhat neglected until the past two years. There were poor physical facilities, inadequate staff and no provisions for rendering that type of care. According to VA regulations, there was very little that could be given in the way of care to a veteran applicant unless he was service-connected. Recently, however, the VA has recognized that the Outpatient Service is the first part of the hospital that meets the patient coming in. Among the problems here are the many times the veterans cannot see the physician, they don't come at the right time or were not scheduled. We haven't had the facilities, organization or personnel to take care of them, and the services hasn't been very effective.

During the past few months, a lot of time, effort and money have gone into improving the physical facilities and upgrading personnel, with the addition of eight full-time equivalent personnel to that area —one physician's assistant, one surgeon's assistant, two nursing personnel, three administrative employees and one receptionist who will direct and assist the large number of patients. In addition, the Departments of Medicine and Surgery have assigned residents full time in the Admission Service. Copies of the new policies and procedures for processing the veteran applicants were distributed to the committee members for their information.

Dr. Aldrete stated we are committed to this with the idea it will be much better, faster and more efficient. Dr. Pittman stated this hospital has the name of having the highest rejection rate of any VA hospital in the country. The only one with a higher rate is San Juan, and he believed there were some patients who needed to be in the hospital that were not admitted. He indicated it was a controversial area with the housestaff when they believe there is unwarranted pressure, yet in Washington they see letters from congressmen stating patients are rejected and die shortly afterwards. He stated it did not take many of these cases to attract interest.

Mr. Cox discussed the inadequate facilities, poor administrative support, etc., which made it extremely difficult for the housestaff in the past few years. Under the new plan, when the patient arrives he will be immediately registered, eligibility deter-

mined, records retrieved and he will go through the screening process promptly. This will include all steps of the examining process that can be done by the nurse practitioner, surgeon's or physician's assistant, including the ordering of laboratory and radiological studies. All the above will be accomplished before the physician becomes involved, and the patient's records will be there. According to Mr. Cox, this will eliminate many of the problems that have plagued the housestaff in the past.

Frequency of Deans Committee Meetings

Future meetings will be held bimonthly; they will be briefer; and more can be accomplished. It was decided the next meeting will be held on Thursday, September 27, at 3:00 p.m. This is the day before the dedication of the new dental building, and several distinguished visitors from Washington plan to attend the meeting, in addition to the dedication ceremony.

VA Appointments—Legal Requirements; Pay From Source Where Service is Performed; Outside Activities for Full-Time Physicians, Dentists and Nurses for Remuneration

Dr. Pittman reviewed the legal requirements set forth in VA Circular 00-70-22, which originated with the Administrator. Although this regulation was not too well received by the professional staff at the time, it was pointed out that it is the law that a professional employee must actually work in the VA hospital the number of hours for which he is paid, and that particular individual himself must be paid for the services he renders and not a colleague or another individual who renders service as a WOC (without compensation) official. Dr. Pittman previously referred to House Committee Print 167, Parts I and II, which is a somewhat confidential report of irregularities in the VA hospitals. Dr. Sheehy discussed some adjustments in appointments to the Department of Medicine so that there can be no question of being within the legal requirements. Dr. Pittman emphasized that it is a matter of payment for services for patient care—not education—but for patient care, and we have no choice but to live with it and explain it to the faculty and staff in order to make it work well.

Dedication of New Dental Building

The dedication of the new Dental Educational and Training Facilities Building will be held on the morning of September 28. The Administrator of Veterans Affairs will be among the distinguished guests. These will include Dr. R. M. Whittington, our Regional Medical Director. Mr. Cox invited input from those present, and suggested they contact Mr. Joe D'Angelo who is coordinating the guest list. Several names were mentioned, including Dr. Krajicek, former Assistant Chief Medical Director for Dentistry, and Dr. Jack Sharry, Dean of the School of Dentistry, Charleston, South Carolina, with the hope they might be able to attend.

There being no further business, the meeting adjourned at 3:50 p.m.

Submitted by:
Marinelle Hines
Secretary

Approved:
James A. Pittman, Jr., M.D.
Chairman

SPECIAL REFERENCES

Presidential Executive Order 5398, July 21, 1930. (Public Law 536-71st Congress - Reorganization Act of July 3, 1930).

79th Congress: *Public Law* 293, January 3, 1946.

Adkins, R. E.: Medical Care of Veterans. House Committee Print No. 4 90th Congress 1st Session. April 17, 1967. U.S. Government Printing Office. Washington, D.C. 1967, p. 2.

Veterans Administration, *Policy in Association of Veterans' Hospitals with Medical Schools*, Policy Memorandum No. 2.

Magnuson, P.B.: *Ring the Night Bell*. Little, Brown & Co., Boston, Mass. 1960.

Letter of Agreement Between the University of Alabama in Birmingham and VA Medical District #14, March 30, 1972.

Veterans Administration, Department of Medicine and Surgery, Interim Issue 10-73-9, June 13, 1973.

Public Law 89-785, Title I, Veterans Hospitalization and Medical Services Modernization Amendments of 1966. November 7, 1966.

Lewis, B. J.: *VA Medical Program in Relation to Medical Schools.* House Committee Print No. 170, 91st Congress, 2nd Session. January 19, 1970. U.S. Government Printing Office, Washington, D.C., 1970.

Musser, M. J.: Medical Education Opportunities in the Veterans Administration. *Military Medicine*, V. 137 (August 1972), 331-34.

Lewis, B. J.: Veterans Administration Medical Program Relationship with Medical Schools in the United States. Part I. Washington, D.C.: *The American University*, 1969, p. III-IV.

Irregularities in the Salt Lake City, Utah, Veterans' Hospital and Other Stations, House Committee Print No. 167, Part II, 91st Congress, 2d Session, September 21, 1970. U.S. Government Printing Office, Washington, D.C.

DM&S Circular 00-70-22, June 3, 1970. Outside Professional Activities of Full and Part Time Physicians, Dentists, Residents, Nurses and Nurse Anesthetists Employed Under Title 38, USC, Ch. 73.

Fove, Jr., L. V., Director, Education Service of the VA-DM&S, VACO. Memorandum to Deputy Chief Medical Director. Essential Increase in Postgraduate and Inservice Training Fund (815), May 30, 1972.

93rd Congress: *Public Law* 93-82, August 2, 1973, Veterans Health Care Expansion Act of 1973.

Hill, Jr., S. R., Vice President for Health Affairs, Birmingham, Ala.: Letter to M. J. Musser, Chief Medical Director of the VA Central Office, May 22, 1973 (Xeroxed).

Proposal for Establishment of a Regional Medical Education Center at VAH Birmingham, June 8, 1973 (Xeroxed).

Pittman, J. A.: *Medical Research in the VA.* Memorandum prepared for Research & Education Council, VA Central Office, Washington, D.C. July 17, 1972.

85th Congress: *Public Law* 85-857, Sec. 4101, September 2, 1958, 72 Stat. 1243 (1958).

(Unsigned): After twenty-five years. *Lancet* 1:1469, 1973.

Condliffe, P. G. & Furnia, A. H.: *Reform of Medical Education. The Role of Research in Medical Education.* Washington, D.C., Government Printing Office, 1970.

STATEMENT OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ON THE

NATIONAL ACADEMY OF SCIENCES/NATIONAL RESEARCH COUNCIL REPORT

HEALTH CARE FOR AMERICAN VETERANS

Mr. Chairman and Members of the Subcommittee:

I am James Pittman, M.D., Executive Dean of the School of Medicine of the University of Alabama at Birmingham. I am appearing today on behalf of the Association of American Medical Colleges. The Association is pleased to have this opportunity to testify before the Senate Committee on Veterans Affairs during its consideration of the National Academy of Sciences Report entitled Health Care for American Veterans.

Now in its 101st year, the Association represents the constituency of institutions and organizations principally involved in the undergraduate and graduate education of physicians. It serves as a national voice for all of the 120 operational U.S. medical schools and their students, for over 400 of the major teaching hospitals and for 62 learned academic societies whose members are engaged in medical education, research and service. Because of the extent of the medical school-VA affiliations, the report of the National Academy of Sciences on the VA health care system is of direct and significant interest to the constituency of the Association and may have far reaching implications for the programs of these institutions.

Presented by James Pittman, M.D., Executive Dean of the School of Medicine of the University of Alabama at Birmingham, to the Committee on Veterans' Affairs, United States Senate, October 17, 1977.

The Association has carefully reviewed the report of the NAS/NRC Committee published in June and feels that the authors should be complimented for a generally sound and thorough study, in June. The AAMC testimony today will focus principally on chapter 16, "Affiliation of VA Hospitals with Medical Schools", a subject on which the Association has the greatest knowledge, expertise and interest and which is most relevant to its concerns.

The VA/Medical School Relationship: The relationship of VA hospitals and academic medical centers dates to the immediate post World War II period when under the leadership of two great visionary architects of the program, Dr. Paul Magnuson and General Paul Hawley, the modern VA medical care system was built from the ruins of its earlier history. This inspiring chapter in the history of the Veterans Administration is too well known to all of you to warrant detailed review at this time. I would only like to recall for the record that the policy designed to serve as the cornerstone of the new program, and to provide the key to its hoped for success, was to couple these hospitals to a highly respected institutional form in our society, the medical school. Thus was created one element in the modern academic medical center. This partnership took official form in 1946, when the VA formally committed itself to participate with the schools in the provision of graduate medical education. The basic division of responsibility agreed upon was for the VA to retain full responsibility for the care of patients, including professional treatment, and for the medical schools to accept the responsibility for all graduate education and training. It was clearly understood that even though there was a division of respon-

sibility, the two functions were inseperably interrelated. With Congressional ratification of this policy, a series of Dean's Committees was created, each of which included senior medical school faculty members nominated by the Dean of the affiliated medical school and appointed by the Chief Medical Director of the VA. Each Dean's Committee was directed to cooperate with VA personnel in establishing medical residency programs and in determining the scope, organization, and standards of performance for these programs and the adequacy of facilities.

The system of Dean's Committees has turned out to be a remarkable invention which enabled the relationship between the VA and the medical schools to flourish. Once a Dean's Committee is constituted, the VA hospital and medical school are authorized to work out the details of a relationship. This modus operandi has worked brilliantly. Since 1946, the partnership between the VA and the medical schools has grown dramatically and become increasingly complex and productive. The original affiliation agreements have been complemented by: sharing agreements, contracted to minimize the duplication of scarce and specialized resources; awards by the VA to affiliated medical schools; the development of new state medical schools with VA affiliation; and the education of health professionals in over sixty health occupations. Today affiliations with academic medical centers involve 133 VA hospitals with 103 of the nations 120 operative medical schools, nearly twice the commitment in 1948. An examination of the Directory of Accredited Residencies by the Liaison Committee on Graduate Medical Education, published in 1975, indicated that these arrangements encompassed

7,151 filled housestaff positions in 85 hospitals, of which approximately 4,000 were in internal medicine, 2,300 in surgery and 600 in psychiatry. VA hospitals thus provided 38% of the total of filled housestaff positions in internal medicine in the U.S. in 1974-75, 16% of those in surgery and 14% of those in psychiatry.

The Association is pleased with the assessment of the NAS/NRC report regarding the value of VA affiliation with medical schools and, at the risk of appearing self-serving, would like to quote with pardonable pride from the report. It states:

> "The VA policy of affiliating with medical schools ... has resulted in an extensive, complex, and varied pattern of mutual dependence: of VA hospitals on medical schools for physicians, and of medical schools on VA hospitals for resources essential for educational and research programs. These relationships have been beneficial to all parties concerned. For the VA, the affiliation relationships are very closely related to the quality of acute inpatient care in VA hospitals. In the sample of hospitals studied by the Committee, the only examples of outstanding quality of care were found in hospitals that are highly affiliated. The only hospitals found to be delivering inadequate acute care were unaffiliated. For the medical schools, the VA affiliations are important primarily because their educational programs require access to acute care patients to teach medical students and to train residents".

The report further states that:

> "The quality of care furnished to the nation's veterans has

improved, and the educational enterprise has been promoted". The reasons for this NAS/NRC conclusion we believe are really quite simple. The juxtaposition of a VA hospital and a medical school creates a favorable environment for teaching, research and patient care and this results in a positive benefit for both parties. Among the advantages to the VA is that it markedly enhances its ability to recruit distinguished physicians and quality house officers to its staff. The overall result is greatly improved medical care for the veteran and a rich and stimulating intellectual environment, beneficial to both faculty and students. Moreover, affiliation with medical schools has provided the setting to transfer rapidly the results of the search for new biomedical knowledge into improved patient care. This concentration of resources and facilities has fostered the most sophisticated care available and brought world renown to a number of VA hospitals, and also enabled the system to participate significantly in meeting its own health manpower needs.

Against this background the Association of American Medical Colleges is convinced of the wisdom of the Magnuson/Hawley premise and believes, as does the NAS/NRC Committee, that these VA/academic medical center relationships should be encouraged and improved, wherever possible, in order that as a nation we will be better equipped to provide the best possible medical care to our veterans and to produce significant numbers of highly qualified physicians.

One of the ways which could strengthen affiliations and at the same time prevent erosion of currently productive arrangements is to increase the number of residency positions in the VA system. At

the present time the number of positions authorized by Congress has not kept pace with the demands on the VA system. Moreover, with the building of new medical schools and the need for additional primary care residency slots to meet the requirements of P.L.94-484, the Health Professions Educational Assistance Act of 1976, the VA, at the same time that it is providing better patient care to the country's veterans, has an opportunity to be responsive to the clearly articulated Congressional mandate that approximately 50% of graduate medical education positions be in primary care.

While the Association strongly supports VA affiliations, limitations to such arrangements should be clearly recognized. Both the AAMC and the NAS/NRC report concur that wherever a mutually beneficial relationship can be developed, it should in fact be encouraged. On the other hand, absent appropriate ingredients, the relationship can fail. Productive affiliations require commitment, adequate resources, physical proximity, daily interaction, a sense of common purpose, and constant monitoring and evaluation. Good intentions are necessary but not sufficient. Thus a VA hospital and a medical school 400 miles apart would find that the probability of developing a satisfactory, mutually rewarding, cost-effective relationship are quite low and probably not worth putting forth the necessary effort. For this reason, the AAMC would recommend that to overcome the difficulties imposed by distance alone that future construction plans for new VA hospitals take into consideration the location of the medical school if the VA is desirous of having strong affiliation agreements.

47-660 O—85——6

Sharing and Regionalization: The NAS/NRC report, in addition to strong support of the policy of VA/medical school affiliations also endorses strongly the principle of resource sharing. The Committee points out, however, that the authority to develop sharing agreements has been exercised to only a very limited extent.

The basic authority for the VA to share specialized medical resources was originally made available in 1966 in P.L.89-785. Although informal sharing arrangements predated it, this legislation was essential to permit and formally encourage VA hospitals to share underutilized, specialized, scarce, and costly resources that belonged either to the VA institution or to contiguous academic medical centers, community hospitals, and other community health facilities. The intent was to maximize the utilization of existing local resources and to eliminate the need for the development of duplicative ones. Then and now, the statute requires that the sharing of resources cause no reduction in service to the veteran and that provision be made for reciprocal reimbursement.

Since enactment of the legislation ten years ago, both the VA and the health care community at large have reaped substantial benefits from sharing agreements, most of which have been renewed annually with new items and services added to contracts each year. At present, 83 VA health care facilities have entered into 184 sharing agreements with community health care facilities with the annual payments for services by both parties amounting to approximately $14,000,000. When measured against the four billion dollar budget of the VA health care system, it is clear that sharing

agreements have constituted a mere fraction of the annual expenditures.

The AAMC concurs here as well with the conclusions of the NAS/NRC report -- that sharing agreements have yet to be developed to the maximum extent feasible, that they be expanded wherever possible, and that the scope of the sharing law be broadened to include a wider range of services. From the AAMC's perspective, sharing represents an attempt to maximize the use of resources within a geographic area and constitutes a powerful device to extend and strengthen affiliation agreements to the benefit of all parties.

One countervailing force to the further development of sharing agreements is the VA regionalization program, instituted in 1966, approximately the same time as the sharing program. Since the primary objective of the VA regionalization program is to improve patient care and delivery of health care services through the most effective and efficient use of VA resources in a specified region, this program encourages VA hospitals to "share" resources within their own system, with the inevitable effect -- looked at from a different perspective -- of diminishing the sharing of resources between the local VA hospital and the academic medical center in those situations in which medical center/VA hospital affiliations acutally or potentially exist. The AAMC cannot fault the logic and common sense behind the VA regionalization program. However, given a choice between developing sharing contracts with the local community (e.g. with a medical school) or developing a sharing arrangement with a VA hospital in the larger VA region,

the AAMC and its constituent academic medical centers would hope that the VA would see the strong advantages for the VA system at large in building on the affiliation and capitalizing on the resources unique to an academic medical center. Moreover, when given the option, most patients would prefer to be hospitalized in their own community rather than have to travel to a different location for treatment at another VA hospital. This is not to say that we believe that the regionalization program has no place in the system. Quite to the contrary. Some VA hospitals are not in a position to develop an affiliation with an academic medical center, and therefore the resources of other VA hospitals become critical. The AAMC believes that sharing of resources between VA hospitals within a region should be planned with firm attention paid to the necessity of strengthening the relationships between the affiliated VA hospital and the medical schools and insuring the delivery of contemporary patient services.

A Joint Affiliation Study: An Effort In Long Range Planning: As part of the effort to strengthen affiliations, the AAMC supports the NAS/NRC recommendation that "the VA in cooperation with the medical schools undertake a careful study of affiliation relationships as a basis for planning necessary adjustments to realistically meet the needs of both parties." We concur strongly with this recommendation because we believe that such a joint study could define the character and measure the degree of interdependence of the two systems and thus provide a basis for the continuing evolution of their relationship. The delivery of health care services to the veteran can only be expected to improve as a result of such a study.

In addition to answering the questions related to affiliation, a joint study could focus on the inherent conflict between sharing and regionalization. Moreover, it could be directed toward the development of a contingency plan in the event that there is a major transformation in the health care delivery system of this country by the adoption of some form of national health insurance. While this issue may appear academic at the moment, it would be highly desirable to explore the whole range of reasonable options and examine the consequences of each on the existing VA/academic medical center relationship.

In summary the AAMC generally agrees with those aspects of the NAS/NRC report which relate to affiliation agreements and their importance to both the VA system and medical schools. Toward that end we will continue to support the extension, expansion and strengthening of these agreements through the development of more extensive sharing agreements on the one hand and selective, discrete and sensitive implementation of the VA regionalization program on the other. The academic medical centers of this country stand prepared to cooperate with the VA in the adoption of other NAS/NRC recommendations, where these are relevant to and concordant with the goals and objectives of medical education. A joint study of affiliation agreements seems to us to be a logical first step as we begin to plan for the years ahead.

~~The Association appreciates the opportunity to present its views to you today. I'll be glad to answer any questions.~~

Testimony Before Senate Veterans Affairs Committee

October 17, 1977

Washington, D.C.

Mr. Chairman -- I would like, as Dean of a medical school highly affiliated with the VA system, to add some brief personal observations. I must differentiate these personal observations from the foregoing statement, which was endorsed by the AAMC Executive Committee.

First, the ultimate and basic goal of the VA and the medical schools is the same -- high quality care for sick people. How does one teach young people to practice medicine? There is one over-riding way: by example, by providing exemplary patient care....exemplary patient care....by the best physicians one can find. Lectures, slide shows, conferences, books and the like cannot teach the attitudes and judgment required for the mature practice of clinical medicine. If one accepts this premise, the goal of the VA and the medical schools is basically the same. Conflicts are more apparent than real, and such conflicts, if exaggerated, are destructive not simply of VA and medical school operations but of patient care.

Second, the present VA/AAMC Liaison Committee was formed in 1976 and met for the first time in January 1977. The AAMC concurs with the NAS/NRC Recommendation Number 33:

> "The Committee recommends that the VA in cooperation with the medical schools undertake a careful study of affiliation relationships as a basis for planning necessary adjustments to realistically meet the needs of both parties."

The two institutions are so intertwined that unilateral planning or actions by either the medical schools or the VA may be disruptive or even destructive of the other.

I'd like to quote from a classic book by Dr. Benjamin J. Lewis, titled VA Medical Program in Relation to Medical Schools. (In the Preface, page Roman numeral v) Dr. Lewis says:

> "The writer, a long-time employee of The Department of Medicine and Surgery in the Veterans Administration.... had never thought of the daily joint activities of many of these hospitals and medical schools as representing a simple entity with a life of its own -- a simultaneous enricher of both government and higher education."

I agree with Dr. Lewis that a VA-medical school affiliation represents "a single entity." Thus, I believe the assessment of affiliations requires a joint effort, a joint effort, by both the AAMC and the VA -- not either alone.

Lastly, I would point out a specific, personal illustration of how a medical school can enhance VA operations to the benefit of the veteran, from my own medical school.

In April, 1976, I wrote, as Dean, the VA Central Office requesting that a consumer -- a veteran with no other special credentials -- be appointed a member of our Dean's Committee. In July 1976 (July 27) VACO responded negatively but permitted us to invite a veteran to attend meetings as an observer. In January 1977 I again brought this up, as a member of the VA/AAMC Liaison Committee. This time the Chief Medical Director and his immediate staff gave it personal attention, and in April 1977 letters were sent out from the Chief Medical Director in VACO to VA Hospital Directors and to medical school deans endorsing the idea of a veteran representative on the Dean's Committees. (Copies of these letters are included in the VA response to NAS/NRC.) Finally, on April 5, 1977, Mr. "Lefty" Wadsworth, that is Mr. W. W. Wadsworth, Director of the Department of Veterans Affairs for The State of Alabama, was officially appointed a member of our Dean's Committee. Mr. Wadsworth is a member of the VFW, the American Legion, the DAV, and other organizations. And I can provide data to support the statement that he has brought specific cases of veterans' problems to the attention of the Dean's Committee, to the direct benefit of the veterans and the improvement of operations. Thus, here is an example of a medical school initiative directly related to improving veteran patient care. Other examples could be cited of VA initiatives which have improved medical education.

It is important for all concerned that these affiliations not only survive but thrive, for the VA, the schools, -- and especially the patient.

Thank you.

James A. Pittman, Jr., M.D.
Dean, University of Alabama School
of Medicine

STATEMENT OF HON. ANN BEDSOLE, ALABAMA STATE SENATOR

GOOD MORNING, GENTLEMEN --

I AM ANN BEDSOLE, AN ALABAMA STATE SENATOR. I SERVE ON THE SENATE VETERAN AFFAIRS COMMITTEE AND AM CONCERNED AND INVOLVED WITH VETERANS' HEALTH CARE PROBLEMS IN THIS STATE -- AND HAVE BEEN FOR YEARS, BUT TODAY I WANT TO BRING TO YOUR ATTENTION ONE SPECIAL ITEM THAT IS OF GREAT INTEREST TO ME, AND THAT IS A STUDY DONE FOR OUR STATE DEPARTMENT OF VETERANS AFFAIRS. WE HAVE JUST PAID OVER $60,000 TO ERNST & WHINNEY FOR A THOROUGH STUDY OF THE NEED FOR STATE VETERANS' HOMES IN ALABAMA.

SOUTH ALABAMA HAS NO VETERAN HOME BEDS AT ALL. THE STUDY IDENTIFIED THAT MORE THAN 1,000 WERE NEEDED. FOR THIS REASON, MOBILE WAS PLACED NUMBER ONE ON THE SITE SELECTION LIST. PRELIMINARY SITE RANKING WAS BASED ON MOBILE'S HAVING -- AMONG OTHER ITEMS OF CRITERIA -- THE SECOND LARGEST CONCENTRATION OF VETERANS IN ALABAMA AND, IN FACT, IN ALL OF DISTRICT TEN.

IN THE STUDY, ENTITLED "CARING FOR THE OLDER VETERANS", IT IS NOTED THAT WHILE THE VA HAS ONLY 15,000 VETERANS UNDER LONG-TERM CARE TODAY, THAT NUMBER WILL EXPLODE TO 760,000 IN 15 YEARS. NOT ONLY THE VETERANS ADMINISTRATION, BUT THE STATE OF ALABAMA, MUST RESPOND TO THOSE NEEDS.

ONE IMPORTANT PART OF THE PROVIDENCE COMPLEX IS A 126-BED SCHOOL OF NURSING. THIS NURSING HOME FACILITY, IN CONJUNCTION WITH A VA HOSPITAL, WOULD MAKE ONE OF THE MOST EXCEPTIONAL FACILITIES IN THE NATION. ALABAMA WILL BE VITALLY INTERESTED IN THIS FACILITY WHEN THIS PROJECT SUCCEEDS, AND I ASSURE YOU --

AS I KNOW THE GOVERNOR WILL, THAT WE ARE FULLY SUPPORTIVE OF THIS PROJECT AND DETERMINED TO SEE OUR VETERANS BETTER SERVED BY THE VA.

I ALSO SERVE ON THE HEALTH COMMITTEE OF MOBILE UNITED. THIS ORGANIZATION HAS PASSED A RESOLUTION WHICH THEY ASKED ME TO BRING TO YOUR ATTENTION TODAY, AND I WOULD LIKE TO READ THAT AT THIS TIME --

RESOLUTION

THANK YOU.

WHEREAS, Mobile United is a volunteer organization representing a broad cross section of the Mobile community, whose sole purpose is to seek a better quality of life for the citizens of the Mobile area, and

WHEREAS, the Health Services Committee of Mobile United is vitally concerned with quality and readily accessible health care for all the citizens of this community, and

WHEREAS, the Veterans Administration has the opportunity to purchase the existing Providence Hospital site at a cost of $24 million, as opposed to constructing a new facility at a cost of $90 to $100 million, and

WHEREAS, the Mobile area and adjacent counties have one of the largest concentrations of veterans of any area along the Gulf Coast, and

WHEREAS, the Providence Hospital site has immediate access to the services of the University of South Alabama College of Medicine, in compliance with the policies of the Veterans Administration,

NOW THEREFORE BE IT RESOLVED that the membership of Mobile United go on record requesting the Veterans Administration give Mobile the opportunity to serve the courageous American veterans of this area by serving as the home of the newest veterans hospital site in the Gulf Coast region.

Done this day of March 12, 1985.

DR. NORMAN J. BERGER
Chairman, Health Services Committee

DR. STEPHEN F. DILL
General Chairman, Mobile United

R. J. PEARSON, JR.
Executive Director, Mobile United

TESTIMONY OF

FRANK D. WILKES

MR. CHAIRMAN, CONGRESSMAN MOLLOHAN AND CONGRESSMAN DOWDY...

GOOD MORNING GENTLEMEN AND WELCOME TO ALABAMA. AS DIRECTOR OF THE ALABAMA DEPARTMENT OF VETERANS AFFAIRS, REPRESENTING 437,000 VETERANS, PLUS THEIR DEPENDENTS, I AM EXTREMELY PROUD TO HAVE THE OPPORTUNITY TO SHARE MY THOUGHTS WITH YOU REGARDING THE CONVERSION OF PROVIDENCE HOSPITAL IN MOBILE, TO A VA MEDICAL CENTER. WITH YOUR PERMISSION, I WOULD LIKE TO INTRODUCE SEVERAL distinguished MEMBERS OF THE STATE BOARD OF VETERANS AFFAIRS WHO ARE PRESENT HERE TODAY, SUPPORTING THE PROVIDENCE PROJECT.

MR. WARREN S. REESE, JR., VICE CHAIRMAN, REPRESENTING THE V.F.W.

MR. FLOYD E. FANN, REPRESENTING THE AMERICAN LEGION.

MR. WILLIAM F. GREEN, REPRESENTING THE D.A.V.

MR. OSCAR BATES, REPRESENTING THE V.F.W.

MR. LEWIS MC CRAY, REPRESENTING THE AMERICAN LEGION,

MR. BUDDY EUNICE, REPRESENTING THE D.A.V.,

MR. RAVEE HUGHES, REPRESENTING THE V.F.W.,

JUDGE TELFAIR MASHBURN, REPRESENTING THE V.F.W.

FOR MANY YEARS I HAVE BEEN KEENLY AWARE OF THE LACK OF COMPREHENSIVE, VA MEDICAL CARE SERVICES IN EXTREME SOUTH ALABAMA, MISSISIPPI, AND THE PANHANDLE OF FLORIDA. THE LACK OF HIGH QUALITY MEDICAL AND SURGICAL SERVICES HAS FORCED TREMENDOUS BURDENS ON THE VETERANS FROM THIS REGION. PRESENTLY, THESE VETERANS MUST TRAVEL GREAT DISTANCES TO EITHER NEW ORLEANS, LOUISIANA, JACKSON, MISSISSIPPI, BIRMINGHAM, ALABAMA OR TAMPA ST. PETERSBURG, FLORIDA, IN ORDER TO RECEIVE THESE TYPE SERVICES FROM A VA MEDICAL CENTER. I UNDERSTAND THAT WHENEVER THE VETERANS ADMINISTRATION CREATES A MEDICAL CENTER, THE FIRST PRIORITY IS TO ESTABLISH AN AFFILIATION WITH AN ACCREDITED MEDICAL SCHOOL. PROVIDENCE OFFERS THE PERFECT OPPORTUNITY FOR AFFILIATION WITH THE REKNOWNED UNIVERSITY OF SOUTH ALABAMA COLLEGE OF MEDICINE.

MR. CHAIRMAN, THIS COMMITTEE FULLY REALIZES THE RAPIDLY GROWING WORLD WAR II VETERAN POPULATION INTO THE SUNBELT STATES. ALABAMA'S WORLD WAR II VETERAN POPULATION IS EXPECTED TO DOUBLE OVER THE NEXT TEN YEARS TO OVER 150,000. THE PROVIDENCE OPPORTUNITY WOULD ALLOW FOR HIGHLY COMPETENT MEDICAL AND SURGICAL PHYSICIANS TO TREAT THE MOST DESERVING CITIZENS OF THIS REGION, OUR VETERANS.

IN ADDITION, THE AFFILIATION WOULD ESTABLISH A TREMENDOUS SITUATION FOR HIGH TECH. MEDICAL RESEARCH, PLUS PROVIDING THE MEANS TO TRAIN MEDICAL SUPPORT PERSONNEL WHICH WILL BE HIGHLY BENEFICIAL TO THE ENTIRE MEDICAL PROFESSION.

GENTLEMEN, I WOULD APPRECIATE YOUR CAREFUL EVALUATION OF THIS ISSUE AS A ONCE IN A LIFETIME OPPORTUNITY TO ACQUIRE A CRITICALLY NEEDED VA MEDICAL FACILITY AT A FRACTION OF NEW CONSTRUCTION COSTS.

MR. CHAIRMAN, AS THIS COMMITTEE IS AWARE, THE CONSTRUCTION COSTS OF THIS NATION'S VETERANS HEALTH CARE SYSTEM DOUBLED IN REAL TERMS BETWEEN 1970 AD 1980. IT IS A KNOWN FACT THAT THE MEDICAL AND LONG TERM HEALTH CARE NEEDS OF OUR AGING VETERAN POPULATION IS ESCALATING RAPIDLY, AND AS VA ADMINISTRATOR WALTERS STATES, THE QUESTION IS NOT WHETHER THE VA WILL MEET THESE NEEDS, BUT HOW? IN ADDITION, ONE OF THE MOST SIGNIFICANT FINDINGS OF THE GRACE COMMISSION REPORT WAS THAT THE NATION'S HEALTH CARE COMMITMENTS TO ITS VETERANS CAN BE MET AT SUBSTANTIALLY LESS COST OVER THE LONG RUN, IF THE CURRENT VA POLICY FRAMEWORK IS ADJUSTED. OBVIOUSLY, THE 1984 VA DISTRICT TEN MEDIPP REPORT TOTALLY IGNORED THE MANDATE BY ADMINISTRATOR WALTERS, TO EXPLORE NEW STRATEGIES IN PROVIDING FUTURE HEALTH CARE SERVICES FOR OUR VETERANS. IN ADDITION, THE 1984 MEDIPP REPORT PROJECTS THAT MOBILE AND ITS SEVEN ADJOINING COUNTIES, PLUS PENSACOLA AND ESCAMBIA COUNTY, FLORIDA, WILL HAVE 104,276 VETERANS LIVING IN THIS AREA BY 1990. BY ADDING SANTA ROSA AND OKALOOSA COUNTIES IN FLORIDA, THIS WOULD ONLY AMOUNT TO AN ADDITIONAL 28,741 VETERANS BY THE YEAR 1990. THEREFORE, OVER 75% OF THE 1990 EXPECTED VETERAN POPULATION, ACCORDING TO THE 1984 VA MEDIPP REPORT WILL BE WITHIN A 60 MILE RADIUS OF THE MOBILE, ALABAMA AREA. SHOULD THE VA ESTABLISH AN INTERMEDIATE CARE MEDICAL CENTER IN THE VICINITY OF FORT WALTON BEACH, FLORIDA, THIS WOULD CAUSE A TREMENDOUS INCONVENIENCE ON THE MAJORITY OF VETERANS IN THIS REGION BECAUSE OF REQUIRING THEM TO TRAVEL 100 PLUS MILES TO THE FORT WALTON FACILITY.

A MAJOR ISSUE IN THE DECISION AS TO WHETHER A VA FACILITY WILL GO TO MOBILE OR THE PANHANDLE OF FLORIDA IS THAT THE NEED FOR SUCH A FACILITY IS <u>NOW.</u> UNDER THE PRESENT TEN YEAR TIME FRAME FOR NEW VA CONSTRUCTION, IT WOULD BE 1995 BEFORE THE FLORIDA PANHANDLE COULD BE ESTABLISHED. PROVIDENCE IS AVAILABLE NEXT YEAR, 1986. IN ADDITION, WITH THE CURRENT CONDITIONS OF TREMENDOUS FEDERAL BUDGET DEFICITS AND THE APPARENT CUTBACK, OR POSSIBLY FREEZING OF

FEDERAL SPENDING, IT IS HIGHLY UNLIKELY THAT THE PROBABLE $100 MILLION FUNDING BY 1995 TO ESTABLISH THE FLORIDA FACILITY COULD REALISTICALLY BE APPROPRIATED.

✓ THE ALABAMA DEPARTMENT OF VETERANS AFFAIRS CONDUCTED AN IN-DEPTH FEASIBILITY STUDY DURING 1984 FOR THE PURPOSE OF THE ESTABLISHMENT OF A STATE VETERANS NURSING HOME. THE PROMINENT ACCOUNTING FIRM, ERNST & WHINNEY, PERFORMED THIS STUDY. THE DEMOGRAPHIC SECTION OF THIS STUDY INDICATED THAT MOBILE AND BALDWIN COUNTIES RANK NUMBERS 2 AND 8 RESPECTIVELY IN THE STATE OF ALABAMA REGARDING VETERAN POPULATION. MOBILE COUNTY HAS SOME 42,500 VETERANS, BALDWIN COUNTY HAS SOME 10,500 VETERANS. THE STUDY ALSO CONCLUDED THAT THESE TWO COUNTIES CURRENTLY HAVE OVER 9,000 VETERANS IN THE 65 AND OLDER CATEGORY. IN ADDITION, THESE TWO COUNTIES HAVE SOME 1,500 VETERANS, AGED 75 OR OLDER, WHO ARE IN IMMEDIATE NEED OF, OR PRESENTLY MAY BE A RESIDENT IN, A LONG TERM HEALTH CARE FACILITY. CURRENTLY, ALABAMA HAS TWO VA MEDICAL CENTERS IN THE STATE WHICH OPERATE NURSING HOME BEDS. THESE ARE TUSCALOOSA AND TUSKEGEE. THEY HAVE A TOTAL OF 232 NURSING HOME BEDS, WHICH CONSTANTLY HAVE LONG WAITING LISTS. TODAY, ALABAMA HAS OVER A 1,200 NURSING HOME BED DEFICIT TO SERVE OUR AGING VETERAN POPULATION. [THE DEMOGRAPHIC ANALYSIS OF OUR FEASIBILITY STUDY REFLECTED SOME VERY INTERESTING TRENDS RELATED TO ALABAMA'S VETERAN POPULATION. THE OVER AGE 65 STATE VETERAN POPULATION EXPERIENCED A 53% GROWTH RATE FROM 1980 TO 1984 AND IS EXPECTED TO GROW ANOTHER 100% BY THE YEAR 1994. IN ADDITION, BY 1994 OVER 30% OF THE STATE VETERAN POPULATION IS EXPECTED TO BE OVER AGE 65, AS COMPARED TO 15% IN 1984.] TO SUBSTANTIATE ~~THESE~~ CURRENT GREAT DEMANDS FOR FUTURE VA NURSING HOME AND LONG TERM HEALTH CARE FOR VETERANS, THE APRIL, 1984 CONGRESSIONAL BUDGET OFFICE STUDY ENTITLED "VETERANS ADMINISTRATION HEALTH CARE: PLANNING FOR FUTURE YEARS" STIPULATES THAT BY THE YEAR 2000, THE DEMAND FOR NURSING HOME CARE WOULD MORE THAN DOUBLE THAT OF 1982. IN ADDITION, THE CBO REPORT INDICATED THAT IF AVERAGE HOSPITAL LENGTHS OF STAY REMAINED THE

mobile also # city for need in the state (over)

SAME IN 1990 AS NOW, THE DEMAND FOR NURSING HOME CARE WOULD INCREASE ABOUT 40% BY 1990. WITH THE PROPORTION OF CARE GIVEN VETERANS 65 AND OLDER RISING 60% TO 78%.

GENTLEMEN, FOR YOUR INFORMATION, PROVIDENCE OFFICIALS HAVE INFORMED ME THAT SHOULD THE VETERANS ADMINISTRATION ACQUIRE THEIR FACILITY, THEY WOULD GLADLY MAKE ARRANGEMENTS FOR THE VA TO TAKE OVER THE EXISTING 126-BED NURSING HOME UNIT WITHIN THE NEXT 3 MONTHS.

IN ADDITION, MR. CHAIRMAN, WITH THE EVER INCREASING FEMALE VETERAN POPULATION IN THIS REGION, PROVIDENCE CURRENTLY HAS A MODERN, OB/GYN DEPARTMENT WHICH HAS 52 OPERATIONAL BEDS. UNDOUBTEDLY THESE SERVICES ARE PRESENTLY UNAVAILABLE IN THIS ENTIRE AREA.

MR. DAVID STOCKMAN, DIRECTOR OF THE OFFICE OF MANAGEMENT AND BUDGET, IN A REPORT TO THE U. S. SENATE COMMITTEE ON THE BUDGET, OFFERED 8 POSSIBLE AREAS FOR FUTURE STRUCTURAL REFORMS AND MAJOR BUDGET SAVINGS. ONE AREA CENTERED ON VETERANS HEALTH CARE. MR. STOCKMAN STATED IN VIEW OF THE EVER INCREASING COSTS OF VETERANS HEALTH CARE, ONE OPTION TO CONTINUE TO PROVIDE THE NECESSARY MEDICAL SERVICES TO OUR VETERANS WAS TO MAKE WIDER USE OF THE EXCESS FACILITIES IN THE PRIVATE HEALTH CARE SYSTEM. WITH THIS THOUGHT IN MIND, THE OFFICIALS FROM PROVIDENCE ARE WILLING TO PERSONALLY COMMIT TO A LEASING ARRANGEMENT WITH THE VETERANS ADMINISTRATION OF PROVIDING 50 TO 100 ACUTE CARE BEDS IMMEDIATELY TO SERVE THE URGENT MEDICAL NEEDS OF THE VETERANS OF THIS REGION. THE PROVIDENCE OFFICIALS WOULD HAPPILY AGREE TO MAKE THESE ARRANGEMENTS FOR 90% OF THE VA'S CURRENT MEDICAL CARE COSTS.

MR. CHAIRMAN, ONE OF THE TOP PRIORITIES OF THE VETERANS ADMINISTRATION IS TO ESTABLISH A DEPARTMENT OF DEFENSE IN VETERANS ADMINISTRATION SHARING ARRANGEMENT TO STAND READY FOR NECESSARY MEDICAL CARE ASSISTANCE, SHOULD A NATIONAL MILITARY EMERGENCY ARISE IN THE FUTURE. PROVIDENCE WOULD BE A PREMIER FACILITY TO PROVIDE WHATEVER MEDICAL AND SURGICAL NEEDS THAT WOULD ARISE OUT OF SUCH A STATE OF EMERGENCY. BY BEING A PORT CITY, THIS WILL ALLOW FOR EASY ACCESS BY ALL MODES OF MILITARY TRANSPORTATION...AIR, LAND AND SEA.

all VA Reports from Washington have been positive!

IN MARCH, 1984, THE VA DEPARTMENT OF MEDICINE AND SURGERY AND THE OFFICE OF CONSTRUCTION CONDUCTED A FACILITY SURVEY OF PROVIDENCE HOSPITAL. DURING THEIR THREE AND A HALF DAY INTENSIVE SURVEY, THIS TEAM EXAMINED THE HOSPITAL FROM BASEMENT TO ROOFTOP. THIS VA TEAM CONCLUDED THAT "THE PROVIDENCE HOSPITAL BUILDING WAS WELL MAINTAINED AND IN GOOD TO EXCELLENT CONDITION". THE TEAM ALSO STATED THA. IF A PROGRAMATIC DETERMINATION WERE MADE TO ESTABLISH A VA MEDICAL CENTER IN MOBILE, THE PROVIDENCE HOSPITAL FACILITY COULD BE ADAPTED TO SERVE THIS ROLE.

MR. CHAIRMAN, NOW IS THE TIME TO RECOGNIZE THE CRITICAL NEEDS OF OUR DESERVING VETERANS IN THIS REGION. I FEEL THAT ONCE YOU HAVE REVIEWED THE INFORMATION PRESENTED HERE TODAY, YOU WILL FULLY REALIZE THAT THE PROVIDENCE CASE IS FEASIBLY AND ECONOMICALLY SOUND. I AM TRULY CONVINCED THAT PROVIDENCE IS TOTALLY JUSTIFIED AND WOULD SERVE THE MEDICAL BEST INTERESTS OF ALL VETERANS IN THIS AREA.

THANK YOU.

CRITICISM OF PRELIMINARY MEDIPP STUDY ON PROVIDENCE HOSPITAL

PREAMBLE

The Preliminary MEDIPP Study on Providence Hospital totally disregards the need for Providence Hospital based upon Veterans population figures, the national budgetary considerations of the Reagan administration and the office of Management and Budget, the challenge to the Veterans Administration to render cost effective health care to Veterans as stated in the recent "Caring For The Older Veteran" published by the VA, and the cost effectiveness of acquiring Providence Hospital. As pointed out by the Pannell Kerr Forster report submitted to Medical District 10, the preponderance of evidence establishes two undeniable facts with regard to the Veteran-specific population along the central Gulf Coast: (1) The Veteran population will increase at a rate in excess of the national average, and (2) The Veteran population will age, requiring a significant increase in Veterans Administration medical services provided to them. The MEDIPP Study recognizes this need in the Mobile area but totally fails to respond to the need. The Study simply rehashes the Florida Panhandle Study done prior to the availability of Providence Hospital, prior to the President's budget cutting efforts in 1984, and prior to the completion of "Caring For The Older Veteran". The following is a detailed discussion supported by facts demonstrating the total inaccuracy of the Preliminary MEDIPP Study.

STATEMENT OF THE ERRORS IN PRELIMINARY MEDIPP STUDY

1. In its recent publication "Caring For The Older Veteran" the Veterans Administration acknowledged that it was facing a "major challenge".

The challenge was that the Veteran population was rapidly aging and their general health socioeconomic status and daily living conditions were changing. The VA characterized the Report "Caring For The Older Veteran" as its response to this challenge (herein referred to as the "Report"). The Report noted that this change in the Veteran population was recently recognized in the published Congressional Budget Office (CBO) Study "Veterans Administration Health Care: Planning For Future Years". The MEDIPP Preliminary Study on Providence Hospital totally disregards the solutions suggested by the Report.

2. One of the two major objectives that the Report seeks is to develop a strategy for construction of VA health care facilities. See, Report page 11-1. One of the two objectives of this strategy is as follows, "Utilize cost-effective non-construction alternatives, such as purchased or leased inoperated facilities, or fee-based care to fill the gap between VA-constructed facilities and projected demand levels." The preface to the Report specifically points out the need to develop "pilot programs" which could be utilized by the VA in meeting its objective. Providence Hospital was disregarded as a perfect "pilot program". The "pilot program" concept was specifically recommended by Senators Jeremiah Denton and Howell Heflin in connection with their study of the Veterans' needs in the Gulf Coast area. The suggestions of the Senators have apparently fallen on deaf ears insofar as the Medical District 10 Study is concerned.

3. The Report noted that new hospital beds at the present time are estimated to cost $245,000.00 per bed. Ralph Casteel's report to Chairman of the United States House of Representatives Committee on Veteran Affairs dated June 28, 1984 estimates a new construction cost of $300,000.00 per bed.

The District 10 MEDiPP Study totally fails to recognize, (a) that the Veterans Administration must consider acquisition of existing facilities as an alternative to new construction, and (b) the fact that at $69,000.00 per bed the Providence Hospital 349 beds can be purchased at 25% or less of the cost of new construction ($250,000.00 less $69,000.00 or $181,000.00 per bed savings). Both of these objectives were an intrinsic part of the strategy in the Report, "Caring For The Older Veteran" and both of these were ignored by the MEDIPP Study. Congressman Earl Hutto has stated that he is willing for the VA to consider Providence Hospital, "if this is truly a very cost-effective way to do things, buying an old hospital instead of building a new one." See, Mobile Press Register, Tuesday, July 17, 1984.

4. In the Alabama Veterans Affairs Study Of Nursing Home Care For Veterans, Ernest and Whinney ranked Mobile first as a potential VA nursing home/domiciliary site due to its location and its major Veteran population. There already exists a real Veteran need for nursing home care which is estimated by Ernest and Whinney to increase 100% by 1994. The Ernest and Whinney study points out that Alabama already has an entitlement of 1,055 nursing home beds with only 240 beds now available. No nursing home beds are presently located in Southern Alabama. In this regard the MEDIPP Study completely ignores the Alabama Department of Veterans Affairs ernest entreaties to Medical District 10 to establish additional nursing home beds in Southern Alabama at Providence Hospital and its Director, Frank Wilkes' personal plea to Mr. Hugh Vickerstaff to satisfy the need for nursing home beds by the acquisition of Providence Hospital.

The Report on page 11-4, notes, "The cost for the new VA nursing home care prototype has been used in estimating the cost of new nursing

home beds ($6.5 million/120 bed unit)." The Report notes that the cost of constructing these beds would be at least $6.5 million. The MEDIPP Study completely ignores, (1) the fact that the acquisition of Providence would provide 126 nursing home beds, the need for which is already proven, and (2) the fact that the $6.5 million cost savings would be in addition to the $181,000.00 cost per bed savings stated above. In other words, the acquisition of Providence could provide hospital beds at 25% or less on the dollar and 126 nursing home beds free. The MEDIPP Study does not even mention this.

5. The MEDIPP Study Scenarios on page 8, mentions an affect on "the proposed Panhandle VAMC in Fort Walton serving the Florida Panhandle." One of the criteria for construction priorities in the Report mandates the VA to consider "availability of alternatives to new construction." See, Report page 11-4. It should be noted that when the proposed Florida Panhandle facility Study was made, Providence Hospital was not available and the Florida Panhandle study was developed without this criteria having been developed. Rather than denounce the Providence Hospital site because of the proposed Florida Panhandle Study, the Florida Panhandle site should have been reevaluated in light of the availability of the Providence Hospital as an alternative to new construction in the Panhandle and the new criteria. These points are exactly the points of the Report and were completely ignored by the MEDIPP Study.

6. Criteria 6 of the Report page 11-5, to be considered is "availability of the health care man power needed to operate the facility." The Florida Panhandle does not have a teaching medical facility such as the University of South Alabama nearby or in the offing. District 10 was informed both by the University of South Alabama School of Medicine and the University of Alabama

in Birmingham that the University of South Alabama School of Medicine was extremely anxious to affiliate with a VA facility in Mobile. Dr. James A. Pittman, Jr., M.D., Dean of the University of Alabama School of Medicine wrote Hugh R. Vickerstaff by letter dated May 2, 1982 regarding the Providence Hospital,

> Certainly, this would seem to me to be a fine idea, since I believe that by affiliating a VA facility or hospital with a medical school serves as the best possible guarantee for quality care for the veterans.
>
> Further, I believe that Mobile is sufficiently removed from the Birmingham area, and its patient referral patterns are sufficiently east-west (versus north-south) to preclude its having any major conflicts with the Birmingham facility.
>
> I am happy therefore to concur in the recommendation that the VA utilize the Providence Hospital area as its Mobile facility and that this facility, rather than the proposed one in Pensacola which would have no immediate connection with a medical school, be the one for the next several decades in that part of the country. (Emphasis added.)

See letter attached hereto.

Dr. Pittman's opinion was completely disregarded by the MEDIPP Study. The Study further fails to make any mention of the University of South Alabama School of Medicine being extremely desirous of affiliating with the VA Hospital in Mobile.

7. In Criteria 8 in the Report at page 11-5, notes that one of the criteria is the "Climate of community and constituent support for the project. A project for which affected groups who could facilitate project implementation and operation indicate strong support would receive additional weight." The support by the Mobile community including all political and non-political organizations, the black community, both Democrats and Republicans as well as the huge support for the project by the local Veteran population was completely ignored by the MEDIPP Study. Copies of support

Resolutions by the Alabama House and Senate, the Mobile City Commission, the Mobile County Commission, and many other local support groups are cited.

8. The Report does not even mention the exhaustive treatment of this subject by Ralph Casteel in his report to Chairman Sonny Montgomery of June 28, 1984. The Casteel report specifically states that, "[T]he Agency be required to show that the Providence Hospital would not be suitable to meet the needs of Veterans in South Alabama and the Panhandle of Florida and that it would not be economically feasible to purchase this property versus new construction." This suggestion by Mr. Casteel was not included in the MEDIPP Study. The Study totally ignores the economy of the Providence Hospital purchase.

Casteel's conclusion in his report which was rejected out of hand by the MEDIPP Study concluded,

> In light of the above, I believe this matter should be further pursued with the Administrator of Veterans' Affairs and my recommendations are that:
>
> 1. Should the VA determine there is a need for a VA Medical Center to serve veterans in the Panhandle of Florida and Southern Alabama, the Administrator be urged to give serious consideration to the acquisition of Providence Hospital, Mobile, Alabama.
>
> 2. Should the VA determine that a new VA Medical Center is to be constructed in the Panhandle of Florida as recommended by the Florida Panhandle Workbook, the Agency be required to show that the Providence Hospital would not be suitable to meet the needs of veterans in South Alabama and the Panhandle of Florida and that it would not be economically feasible to purchase this property versus new construction. This can be accomplished under the authorization process required by section 5004, chapter 81, title 38, U.S.C.
>
> 3. Should the VA opt for new construction in either of the three locations mentioned in the Florida Panhandle Workbook (Fort Walton Beach, Panama City, and Pensacola) the Agency be required to show that staffing of such facility will be ac-

complished without undue difficulty and that the quality of care to be provided will be comparable to or exceed that which is provided in the community of Mobile with a close affiliation with the University of South Alabama School of Medicine.

9. The MEDIPP Study fails to mention the fact that Senator Alan K. Simpson, Chairman of the Senate Committee on Veterans Affairs, wrote to Harry N. Walters, Administrator of Veterans Affairs, on August 27, 1984, stating that Providence Hospital is a well equipped and excellently maintained tertiary care facility and that its location in Mobile suggested benefits for staffing affiliated with the School of Medicine at the University of South Alabama. Senator Simpson's letter specifically mentioned the fact that the VA was faced with the challenge that is indicated in the Report "Caring For The Older Veteran." Senator Simpson's strong recommendation that Providence Hospital be considered in light of this "challenge" was not even cited by the MEDIPP Study. This is particularly important in light of the fact that the letter was based in part upon a personal site visit by Senator Simpson's Chief Counsel Anthony J. Principi, who spent a considerable amount of time and effort making a personal evaluation of the acquisition of Providence Hospital for the Senator.

10. The MEDIPP Study relies upon information supplied by persons such as Dr. Murray Mitts who has never been to Mobile, Alabama to address the issue of Providence Hospital's acquisition. Dr. Mitts has never discussed the matter with the Alabama Department of Veterans Affairs Director Frank Wilkes nor has he ever met with any leaders of the Veterans organizations in the Gulf Coast area concerning the subject of Providence Hospital.

11. The population increase to be generated by the Tennessee/ Tombigbee Waterway which will be officially opened in June 1985 was ignored. The population figures using the MEDIPP Study were based on the 1980 census which is, (1) now four years old, and (2) does not consider the

impact of the Tennessee/Tombigbee Waterway. The Pannell Kerr Forster Study which was recently completed and delivered to Hugh Vickerstaff, Director of Medical District 10 prior to the completion of the MEDIPP Preliminary Study states,

> U.S. Corp of Engineers studies of the Tennessee/ Tombigbee Waterway and Canal Project estimated population increase of 270,000 within the 167 counties affected by the waterway. We estimate the impact of this project on the Veteran population of Mobile and Baldwin Counties to be an additional 2,510 Veterans by 1990. (Emphasis added.)

This is directly contrary to the Preliminary MEDIPP Study conclusion on page 3, which shows a projected decrease in the Veteran population in Baldwin and Mobile Counties by 1990. This is a concrete example of, (1) the erroneous facts pertaining to population contained in the MEDIPP Study, and (2) the refusal of Medical District 10 to recognize facts within their possession.

12. President Reagan has determined that the huge federal deficit must be cut. The VA is charged with rendering health care benefits to an aging and mobile Veteran population. The Sunbelt which includes the Gulf Coast is an area where the Veteran population is moving. The Report "Caring For The Older Veteran" recognizes this challenge. Rather than discussing Providence Hospital in the light of a viable alternative to new construction the MEDIPP Study does not recognize the fact that the Nation is in a budget crunch and must look for cheaper alternatives to health care such as the purchase of the existing facilities. There is a complete absence of a discussion of cost effectiveness in the MEDIPP Study. The Study is simply an effort to avoid change and maintain the status quo. It has been recently suggested that even the cost cutting proposals contained in the Report which state that, "the cost of implementing this strategic health care plan would

require doubling the VA's health budget (to $18 billion by the year 2000) may not be sufficient to meet the nation's budgetary requirements." See, American Medical News, December 21, 1984, "Demand For Care Exceeds VA Resources".

13. The MEDIPP Study on page 9, states that the Veteran population for the five counties of Baldwin, Clarke, Mobile, Monroe and Washington is projected to decrease after 1990. With the Gulf Coast of southern Alabama being in the Sunbelt area where the aging Veteran population is moving and the Tennessee/Tombigbee Waterway opening up, as well as the tremendous oil and gas discoveries offshore of Mobile, this statistic is obviously incorrect. Even if it were true, the MEDIPP Study states that these counties would support 87 medicine and surgery beds in 1990. Using the most conservative figure for new bed construction of $250,000 per bed, these 87 beds alone in 1985 dollars would cost $21,750,000.00. In 1990 dollars, these 87 beds alone would obviously cost more than the $24,000,000.00 asking price for Providence Hospital. Thus, even assuming that the MEDIPP Study population figures are correct, the five county areas (even excluding the Florida Panhandle) will support 87 beds in 1990 and these beds can be acquired now for the same price as new bed construction. Thus, the MEDIPP Study supports a present need for an expenditure of these funds. Furthermore, the MEDIPP Study does not answer the question that assuming that only 87 medicine and surgery beds are needed in the Scenario I five county potential PSA, the Report does not state how these needs are going to be met. One would suppose that the Mobile Veterans supporting this need would have to drive 100 miles to Fort Walton Beach or keep driving 67 miles to Biloxi.

14. In its discussion of Scenario II, the MEDIPP Study admits that the local Veteran population will exceed the projected minimum of 100,000 Veterans by 1990. This is done by simply including the Florida Counties of Escambia, Okaloosa and Santa Rosa. Even excluding Okaloosa County and Santa Rosa County, Florida, a potential Mobile PSA in Scenario II would still exceed the 100,000 minimum limit by 1990. Page 12 of the MEDIPP Study states that the total population of the potential Mobile PSA indicated by Scenario II which includes Baldwin, Clarke, Conecuh, Escambia, Mobile, Monroe and Washington Counties, Alabama and Escambia, Okaloosa and Santa Rosa Counties in Florida has a projected Veteran population of 133,017. If one excludes the Okaloosa and Santa Rosa Counties totaling 28,741 the Veteran population is still 104,276, well above the minimum. It is clear from the above figures that if one only includes Escambia County, Florida (Pensacola) along with the other seven counties in Alabama which unquestionably should be included in a Mobile PSA scenario that there is a need based on the VA's own Veteran population figures for a Veteran Hospital in Mobile.

The MEDIPP Study assumes that a Florida Panhandle Hospital would be located in Fort Walton Beach. Fort Walton is still 40 miles east of Pensacola, Florida, which would not help the Pensacola Veteran population. Also, Fort Walton Beach, Florida is a resort community (not a year round community) which has no University or Medical School. Even assuming that a VA Hospital were built in Fort Walton Beach, the planning process to construction would probably be ten years off. The VA's own projections of the Veteran population in the Scenario II Mobile PSA, excluding Okaloosa and Santa Rosa Counties would exceed 100,000 in 1990 and the MEDIPP Study does not come up with any answers whatsoever regarding how this population will be

served. Casteel's Report states, "The heaviest concentration of Veterans in the area discussed is in Mobile County, Alabama. This is followed by the three most westerly counties of the Florida Panhandle (Escambia, Santa Rosa, and Okaloosa) all of which are located within a reasonable commuting distance of Mobile.

15. The MEDIPP Study on page 13, assumes that the Scenario II Veteran population will be 133,000 by the year 1990 and through the year 2000. It states that this Scenario II would support approximately 200 beds. In today's dollars this 200 beds at the most conservative new construction figure ($250,000.00 per bed) would be $50,000,000.00. Using Ralph Casteel's figure of $300,000.00 per bed the cost would be $60,000,000.00. Providence Hospital with existing 349 beds plus the 126 nursing home beds at $24,000,000.00 is the most cost effective way to meet the recognized need in the MEDIPP Study.

16. The MEDIPP Study on page 20, notes that the Biloxi VAMC has $100,000,000.00 in previously approved construction. This expenditure has been justified by Medical District 10 as "pre-MEDIPP". The MEDIPP Study notes that two-thirds of the Veteran population for the Biloxi PSA reside in Alabama and Florida at 103,000 Veterans by 1990. At today's new construction dollars, the Biloxi VAMC new construction alone should yield 400 additional beds ($100,000,000.00 divided by $250,000.00). Even assuming that the Biloxi facility had this tremendous capacity increase (which it does not) there can be no justification for requiring the Alabama and Florida Veterans (133,000 by 1990) to travel 67 miles (from Mobile) or 167 miles (from Fort Walton Beach) to any facility in Biloxi, Mississippi no matter how much money was spent there. The major distances involved make it a practical impossi-

bility for the Veterans to be served by the Biloxi facility. How can expenditure of $100,000,000.00 which will buy 400 new beds be justified to serve a population which can not get to the facility. One must keep in mind that the people who need to use a hospital facility are sick people and that hospitalization is an immediate need. Use of Biloxi by Mobile and Pensacola area veterans is not working now and will not work in the future.

The Providence project has been treated unfairly in that, it has been required to follow a so-called "MEDIPP process" when the Panhandle project was put together because of political pressure from the Panhandle without justification based upon population figures and need and the Biloxi expenditure of $100,000,000.00 was justified because of the same political pressure and because it was "pre-MEDIPP". The MEDIPP process either has to be applied to Biloxi, Mobile and the Panhandle or to none. It should not be applied only to Mobile and disregarded when talking about the Panhandle or Biloxi simply for the convenience of the VA.

17. The Preliminary MEDIPP Study unduly minimizes the fact that a VA Site Visit Team Report concludes that Providence Hospital is "well maintained and in generally good condition. The newest construction is in excellent condition." Castell further concluded and emphasized that, "If a programatic determination were made to establish a VA Medical Center in Mobile, the Providence Hospital could be adapted to serve in this role." The importance of this factor in cost effective delivery of health care emphasized by the CBO Report and the "Caring For The Older Veteran" Report was simply glossed over by the MEDIPP Study. This glossing over emphasizes that the MEDIPP Study's priorities are diametrically opposed to the wishes of the Reagan administration and the Congress.

18. Harry N. Walters in a recent article entitled "Caring For The Older Veteran", attached hereto, noted that the Veterans Administration will have to consider, "the special needs of the growing number of women veterans. The Preliminary MEDIPP Study ignores the fact that Providence has an existing OBGYN Department which would meet this need.

19. The University of South Alabama Medical School in Mobile presently engages in aging research and geriatric care. They operate a geriatric clinic called the Central Plaza Towers located on Springhill Avenue. The Preliminary MEDIPP Study fails to consider the fact that an affiliation with the University of South Alabama Medical School would enhance aging and geriatric research.

CONCLUSION

The Preliminary MEDIPP Study is wrong both in its facts and its conclusions. The Study has ignored mandates from the Congress, the Office of OMB, Senators Jeremiah Denton and Howell Heflin, Senator Alan K. Simpson, Congressman Sonny Montgomery through his special envoy Ralph Casteel, the pleas of all local Veterans organizations, the head of the Department of Veterans Affairs Frank Wilkes, and the entire Gulf Coast community that would be affected by a VAMC at Providence Hospital. The Study omits consideration of the following important factors which if considered would have clearly demonstrated a need for the VA to purchase Providence Hospital, to-wit:

1. Ralph Casteel report of June 28, 1984.

2. Congressional Budget Office study entitled "Planning For Future Years", April 1984.

3. Honorable David A. Stockman's testimony before the Committee on Budget of the United States Senate, February 2, 1984.

4. AMA Resolutions of February 2, 1984, recommending purchase of existing facilities by the VA.

5. Recommendations of the Alabama Department of Veterans Affairs.

6. Senator Alan K. Simpson's recommendations, August 27, 1984.

7. Dean James A. Pittman, Jr., M.D.'s recommendations of May 2, 1984.

8. University of South Alabama School of Medicines urging to establish a VAMC in Mobile, so that an affiliation could be made.

9. Pannell Kerr Forster independent study report, "Caring For The Older Veteran", October 10, 1984.

10. 1986-1980 Stategic Medical Plan for the VA District 10.

11. Ernest and Whinney "Feasibility Study Relating To Proposed State Veterans Nursing Home (for the) State of Alabama Department of Veterans Affairs', August 6, 1984.

12. United States Corp of Engineers, "Demographic Projection Module", 1984-Tennessee/Tombigbee Waterway Population Projections.

The plea of the Veterans in the Gulf Coast Area has fallen on deaf ears of Medical District 10 which is supposed to represent their interest. If the VA does not purchase Providence Hospital their plight without a VAMC to serve them is set in concrete past the year 2000. The Preliminary MEDIPP Study does not speak to this plight. The Study should be completely discounted as factually inaccurate and totally inconsistent with the need of the Gulf Coast Veterans.

The University of Alabama in Birmingham
University of Alabama System Medical Education Program/Office of the Dean
(205) 934-5391

University of Alabama School of Medicine / (205) 934-5391
College of Community Health Sciences, Tuscaloosa / (205) 348-7942
School of Primary Medical Care, Huntsville / (205) 539-7757

May 2, 1984

Hugh R. Vickerstaff, Director
Veterans Administration Hospital
Birmingham, Alabama

Dear Hugh:

I have been contacted by Mr. Vincent Kilborn of Mobile, Alabama, representing Providence Hospital to enlist my support for the proposition that the U.S. Veterans Administration purchase the old Providence Hospital facility for utilization as a VA facility, after appropriate renovation or construction, at Mobile. Certainly, this would seem to me to be a fine idea, since I believe that by affiliating a VA facility or hospital with a medical school serves as the best possible guarantee for quality care for the veterans.

Further, I believe that Mobile is sufficiently removed from the Birmingham area, and its patient referral patterns are sufficiently east-west (versus north-south) to preclude its having any major conflicts with the Birmingham facility.

I am happy therefore to concur in the recommendation that the VA utilize the Providence Hospital area as its Mobile facility and that this facility, rather than the proposed one in Pensacola which would have no immediate connection with a medical school, be the one for the next several decades in that part of the country.

Please call or write if I might be able to provide further information.

Sincerely,

James A. Pittman, Jr., M.D., Dean
University of Alabama School of Medicine

cc: Stanley E. Crawford, M.D.
218 Cancer Center
Clinical Building
Mobile, Alabama 36688
Vincent Kilborn, M.D.
P.O. Box 1904
Mobile, Alabama 36633

SUMMARY OF CRITICISM OF PRELIMINARY MEDIPP STUDY ON PROVIDENCE HOSPITAL

The following is a concise statement of the criticism of the Preliminary MEDIPP Study on Providence Hospital.

1. The Study disregards the challenge to the Veterans Administration reported in "Caring For The Older Veteran" and the CBO Study "Veterans Administration Health Care: Planning For Future Years".

2. The Study ignores the "Caring For The Older Veteran" Report recommending purchase of existing facilities as a cost effective way to render health care through the year 2000.

3. The Study totally fails to mention the cost effectiveness of purchasing an existing hospital in excellent condition for $69,000.00 per bed as opposed to new construction of $250,000.00-$300,000.00 per bed.

4. The Study does not consider that Providence's 126 nursing home beds is vital to fulfilling Alabama's entitlement of 1055 nursing home beds, none of which are existing in Southern Alabama.

5. The Florida Panhandle Study should have been reevaluated in light of the availability of Providence Hospital as an alternative to new construction and as an alternative to new construction as mandated by "Caring For The Older Veteran".

6. The Study ignores the fact that the University of South Alabama School of Medicine is anxious to affiliate with a VAMC at Providence Hospital, a must for staffing of a VA Hospital, whereas the Panhandle of Florida has no medical school or prospects for a medical school.

7. The Study indicates that community support for a project is one of the criteria to be considered and the Study ignores the bipartisan support by the Gulf Coast community as well as the local Veteran population.

47-660 O—85——7

8. The Study completely ignored all the suggestions and findings by Sonny Montgomery's representative Ralph Casteel who personally investigated Providence Hospital and made extensive findings of fact and recommendations.

9. The Study completely ignored Senator Alan K. Simpson's recommendations which were based upon the personal inspection by his Chief Counsel Anthony J. Principi who made a personal evaluation of the site and the problem.

10. The Study relies upon opinions by Dr. Murray Mitts who has never been to the Hospital nor discussed the matter with people intimately involved such as Alabama Department of Veteran Affairs Director Frank Wilkes or Veterans organizations in the Gulf Coast area.

11. The population figures established by the Corp of Engineers' Report on the Tennessee/Tombigbee Waterway for Mobile and Baldwin Counties indicating an increase in Veteran population by 1990 was ignored, the Study choosing rather to use outdated population figures.

12. The Study completely fails to recognize the problem of rendering quality health care to Veterans in light of the nation's budgetary situation and the search for cheaper alternatives to health care, such as purchase of existing cost effective facilities.

13. Even using the erroneous conclusion that a Mobile based hospital would support 87 beds in 1990 at present day bed cost figures of $250,000.00 per bed, this alone would justify an expenditure of $21,750,000.00 for acquisition of Providence Hospital, which when combined with the $6.5 million present day cost of 120 nursing home beds (total $28,250,000.00) would more than justify expenditure of federal funds to acquire Providence Hospital.

14. Even using the Study's Veteran population figures, with only the

addition of Escambia County, Florida, the Veteran population in the Mobile/Pensacola area by 1990 is projected to be 104,276 which is well above the 100,000 Veteran minimum needed to establish a 200 bed VA Hospital.

15. The Study's conclusion that Scenario II which is based on a Veteran population of 133,000 by the year 1990 in the Mobile/Pensacola area would justify 200 beds at a present day cost of $50,000,000.00, whereas Providence's 349 beds plus 126 nursing home beds can be acquired for $24,000,000.00.

16. The Study applies MEDIPP guidelines to the acquisition of Providence Hospital but ignores the fact that both Biloxi and the Panhandle of Florida were not established without criteria presently required in "Caring For The Older Veteran" and the Report by the CBO to Congress.

17. The Study fails to recognize the fact that Providence Hospital is in good to excellent condition and would qualify as a "pilot project" for determining the cost effectiveness of the purchase of existing facilities.

18. Providence Hospital has an existing OBGYN Department which would assist the Veterans Administration in meeting the needs of the female Veteran population, a fact omitted from the Study.

19. The Study omits reference to the University of South Alabama School of Medicine's existing geriatric clinic and research in the field of aging.

COMMENTARY

Caring for The Older Veteran

By Harry N. Walters

At the turn of the century, veterans of America's Civil War who had reached age 65 already had lived more than 15 years past the average life-span of that time. The average 65-year-old veteran of today can expect to live still another 15 years or more.

In 1980 three million veterans had reached the 65-and-older plateau. By the year 2000, their numbers will have grown to *nine million*.

How to meet that challenge has been the subject of intense study in the VA for years. For the past two years, it has been the focus of a detailed analysis to establish the "how" and the "how much"—the strategies for meeting the challenge and the resource requirements. This analysis has been presented in a report, "Caring for the Older Veteran," which has been made available to Congress, the president and the general public.

Projections of future needs were based on the same four principles that guide today's VA services:

- To assess the individual needs of veterans and to make help available.
- To provide or support the services needed for a veteran to live as independently as possible.
- To provide backup hospital and extended care when necessary.
- To provide a veteran who lacks a proper home, or who needs additional care, with residential accommodations.

Using the results of veteran opinion surveys and data on past use of VA hospitals, we were able to forecast the probable need for VA benefits and services. The following projections assume that the current eligibility requirements for VA benefits will stay the same and that the economy will remain stable.

Harry N. Walters, West Point graduate and former Assistant Secretary of the Army for Manpower and Reserve Affairs, was appointed VA administrator in January 1981.

We have determined that before 1990 we must make changes in the variety of services we offer and we must ensure that we emphasize programs for the elderly.

By 2000, we must be prepared to handle more than 500,000 more inpatients than are projected for 1985. We will need to expand our capacity for outpatient care and make even more dramatic increases in our institutional extended-care programs, involving states and communities.

By the year 2000, nine million veterans will be 65 or older, and cost the VA $20 billion.

We also will need to meet the special needs of the growing number of women veterans.

To meet these projected needs for VA benefits and services, we have identified these nine goals and options:

- To provide high-quality, inpatient acute-care services by increasing bed capacity at least 68 percent and establishing geriatric evaluation units in all hospitals by 2000.
- To provide noninstitutional health and support services that will lessen the need for hospital treatment by expanding the capacity of outpatient clinics to support 26 million visits (up from 19 million now) and adopting outreach programs to detect and prevent illnesses.
- To provide a mix of expanded extended-care programs—such as hospital-based home care, adult day care, and residential home care and nursing home beds—to make sure that veterans receive needed care through the best combination of all types of VA programs for the elderly, with appropriate links to similar non-VA community programs.
- To maintain and expand VA leadership in aging research by establishing 30 geriatric research, education and clinical centers by 1990 and increasing training opportunities.
- To improve financial support services to veterans and to make sure they know about these benefits by establishing a program for improved access to VA services.
- To increase veterans' awareness of VA services through referrals between VA and non-VA programs.
- To provide a sufficient number of gravesites for veterans and their families by increasing burial capacity at national cemeteries.
- To coordinate VA's aging programs with similar programs in the community by establishing community offices in each medical center and providing start-up funds for community-based aging programs.
- Meeting the future needs of all veterans—but particularly older veterans—will, of course, require an increase in funds.

The estimated costs of medical care in 1990 range from $12 billion to $17.7 billion; for the year 2000, $15.3 billion to $19.9 billion.

In this era of financial constraint, all the options we have presented must be considered and debated.

Meanwhile, we need to continue seeking new ways to provide the best possible care to our veterans—new buildings, the latest equipment, extensive research and management techniques that will improve the delivery of care and services.

VA has an enormous task ahead of it. The strategies offered in the aging report should serve as a starting point and a framework for dialogue among the veterans' groups, the administrator and Congress on how best to meet the needs of older veterans.

VA is on the cutting edge in the field of aging research and geriatric care. How we provide care for older veterans will help shape a national system for providing care to all of the aged in America. □

CARING FOR THE OLDER VETERAN

Preface

The Veterans Administration is facing a major challenge — a very rapidly aging veteran population. Although the whole American population is growing older on the average, the growth in the number of aged is much more rapid in the veteran group. By 1990, veterans over 65 will make up more than a quarter of the veteran population and, by 2000, will reach slightly over one-third. In view of the health problems which accompany aging, the Agency can expect both increased demand and different kinds of demands for services. These changes have already begun to appear in the patients using VA's hospitals and outpatient facilities. They are also increasingly being recognized by the larger community; for example, in the recently published Congressional Budget Office (CBO) Study "Veterans Administration Health Care: Planning For Future Years."

In order to learn more about the aging veterans and their general health, socioeconomic status, and daily living conditions, the VA commissioned Louis Harris and Associates to conduct a nationwide survey of 3,000 veterans aged 55 and over. This special study complements VA's ongoing internal planning efforts to determine changing veteran needs. Accurate assessment of veterans' health care needs, and projection of their impact on geriatric concerns in the future have been a high priority item in the Medical District Initiated Program Planning (MEDIPP) activity of the Department of Medicine and Surgery (DM&S) in each of the past two years. Similarly, the Department of Veterans Benefits (DVB) and the Department of Memorial Affairs (DMA) have focused their planning efforts on assessing the effects of an aging veteran population on their elements of the Agency's mission.

The VA has responded to this challenge through the development of a comprehensive report which presents the necessary data, analysis and options from which a necessary policy discussion can occur. This report — CARING FOR THE OLDER VETERAN — is based upon a set of assumptions which not only can but must be carefully debated to ensure that all options are considered to meet the needs of veterans at an affordable cost. Other reports on the challenge, such as the CBO study, and the options they offer will form a welcome addition to the discussion.

In dealing with the effects of aging, the VA has an additional responsibility beyond its mission of caring for the needs of eligible veterans. The nature of the veteran population is such that the VA will face the problems of increased health and income maintenance needs of a large population of older individuals much sooner than will society as a whole. The solutions may become models for dealing with these same needs in the larger population.

This is a responsibility which the VA takes very seriously. Accordingly, a major analytical effort has been undertaken, involving all components of the Agency. The results of more than a year of study, discussion, and review, CARING FOR THE OLDER VETERAN provides a detailed overview of the opportunities presented by this fundamental change in the beneficiary population, and lays out the VA's Goals and Objectives for meeting the needs of that population. This report builds on the fact that the VA already provides health and benefit services to veterans through an organized system. Since planning for the needs of the aged requires above all a systematic and coordinated approach, this is an important factor. When faced with the task of planning for and managing programs for the elderly, the VA's existing organized system is an important advantage over the private sector. It has, for example, permitted the testing and demonstration of several programs for improving services to the elderly in settings similar to those discussed within this report.

In order to meet the needs of the older veteran as outlined in this report, resource investment is an important consideration for discussion. It should be noted at the beginning that the VA presently has responsibility for health and benefit services for all eligible veterans. Thus, judgments concerning resource needs must consider the total veteran user population. Also, aging of the population is occurring within a population already eligible. The choice available to the VA and our nation's policymakers is not whether or not to deal with the problem but rather how to deal with it.

CARING FOR THE OLDER VETERAN consists of two parts. The first part is entitled "Directions For The Future." It identifies the major issues facing the VA in dealing with the aging of its beneficiary population and presents a series of Goals and Objectives. The second part is entitled "The Strategic Context." This fact book profiles the aging issues, both in the population at large and in the veteran population. In addition to its presentation of the needs of the aging veteran, it highlights the VA's existing capabilities, pilot programs, and research efforts directed at the aging issue. It also defines the environment in which planning and program development for the aging veteran must take place. The implementation of a specific course to address the options presented here and elsewhere (such as in the CBO study) will be the outcome of the normal policy decision process over the course of the next 18 months.

The Agency recognizes, as should the reader, that this report is a living document which will change as it undergoes public debate. In some cases, the changes will be toward more specificity as experience permits such specificity. In other cases, it may be away from specificity where experience demonstrates the wisdom of doing so. The VA is committed to a flexible and responsive program for the older veteran, and that requires flexible and responsive strategies. It is intended that CARING FOR THE OLDER VETERAN be both.

APPENDIX II
STRATEGY FOR CONSTRUCTION OF VA HEALTH CARE FACILITIES

The purpose of this appendix is to describe a general construction strategy which would be one option to provide the hospital, institutional long term care,and ambulatory care facilities necessary to meet the real need of eligible veterans who come to the VA to receive health care. Increasingly, this population will include a high proportion of older veterans. This appendix establishes goals and objectives, defines a general approach, identifies assumptions used, describes the costing methodology, and indicates the costs associated with achieving the range of service levels identified in the aging report. The appendix also discusses general criteria for setting construction priorities. Specific detailed planning regarding the expansion of existing hospitals and the size, location and cost of new hospitals, outpatient clinics and institutional long-term care facilities would be provided through the MEDIPP and facility planning processes, after aggregate targets have been set within the policy process. Similarly, opportunities to purchase or lease and operate suitable facilities would be considered as alternatives in decisions to construct, and in determining the extent to which fee-based care might be necessary. The availability of leased facilities and construction goals would affect the extent to which FTEE projections would have to be adjusted to reflect increases in purchases of care from other providers.

A. **Goal**

The goal of this construction strategy is to meet the requirement of physical facilities to achieve the levels of service to veterans identified in Caring for the Older Veteran; to do so in time frames consistent with the projected requirements being placed upon the VA system; and to avoid the building of excess capacity during the period of projection. Table 1 shows the high and low estimates of needed construction and associated costs for each major medical care program.

B. **Goals and Objectives For The Construction Strategy**

Goal: To Conduct An Orderly Expansion Program Which Will Minimize Both Disruption Of High Service Quality And Generation of Excess Capacity After the Peak Demand Years.

Objective: Concentrate construction of new or expanded facilities between 1990 and 2000 to a target level equal to the capacity needed in the year 2020.

Objective: Utilize cost-effective non-construction alternatives, such as purchased or leased and operated facilities, or fee-based care to fill the gap between VA-constructed facilities and projected demand levels.

C. **General Construction Strategy**

Building the facilities required to serve the health care needs of the aging veteran population according to projections in this report would represent an increase in system growth and construction costs. To provide all the facilities needed to meet the recommended service levels in the plan for the older veteran would represent a major challenge, particularly in the near term 1985-1990 period. Construction to meet all of the estimated 1990 service needs would require an increase of up to 140% in VA hospital beds, and an increase of up to 101% in VA-operated long-term care (LTC) beds (nursing home and domiciliary) during the five years after 1985. New construction for out-patient care would represent a smaller effort, however, as most of the increased demand would be accommocated by the new hospitals.

Even if funding in the necessary amounts were available, any of the projected rates of increase potentially would have serious negative impacts on service efficiency and quality of care provided. Furthermore, construction to meet the demand peaks in 2000 (for hospital beds) and 2010 (for LTC beds) could soon result in large numbers of empty VA beds. Consequently, the strategy in this report is designed to phase the expansion of VA facilities over the 15 years until 2000 to facilitate orderly and efficient growth. Additionally, it calls for construction to a service level (i.e., that of 2020) that would meet the Agency's needs for a prolonged 20-30 year period, to avoid creation of a large and increasing excess capacity after the peak demand years. After 2020, the need for facilities will decline, but most VA hospitals will be 50 years old, or even older. Thus closing down some existing buildings would hardly be wasteful.

For hospital care, the result is a gap between VA-owned capacity and the beds needed from 1990 through 2010 which would be filled by leased or purchased facilities operated by the VA or fee-based care (See Table 2). This gap, peaking at from 27% to 55% of the total beds needed in 1990, would steadily diminish until its disappearance in 2020.

Table 1

Construction Strategy Summary Based on Range of Estimates of Real Need
(Beds and Workloads in Thousands — Costs in Millions of Dollars)
Note: Where only a single figure is shown, estimates are the same for all projection methods

	1990	2000	2010	2020
Range of Total Workload Estimates (in thousands)				
Hospital Discharges	1,420-2,310	1,540-2620	1,430-2,520	1,200-2,100
LTC ADC (VA-Operated)	26-35	39-50	43-56	39-50
Ambulatory Care Visits	25,300-32,100	25,700-32,700	23,100-29,300	19,500-25,800
Range of Total Bed Requirements (in thousands)				
Hospital	116-189	134-246	128-225	108-188
LTC (VA-operated)	27-37	41-52	45-59	41-53
Recommended Bed Level to be met by construction for High and Low Estimates of Real Need (in thousands)				
Hospital	85	108-188	108-188	108-188
LTC[1]	27	41-52	41-53	41-53
Construction Costs for High and Low Estimates (in millions of 1985 $)[2]				
Hospital[3]	337.5	5,175.0-23,175.0	225.0[4]	112.5[4]
LTC	351.1	726.3-1,322.2	0-110.5	0
Ambulatory Care[1]	126-253	8.6-35.7	0	0
Total Costs	$814.6-941.6	$5,909.9-24,532.9	225.0-335.5	112.5

[1]Nursing Home and Domiciliary, combined.
[2]Costs are for each entire period, 1985-1990, and 1991-2000, etc. They are for expanded and new capacity only. Facility maintenance, replacement and modernization costs are covered in Appendix III.
[3]Costs for hospital beds include outpatient clinic construction in hospitals. Ambulatory care costs are for new satellite outpatient clinics only.
[4]Hospital construction costs for the 2010 and 2020 periods are to provide for geographical shifts in veteran population, not increases in net bed capacity.

These years of high reliance on leased capacity and purchased services are a period when the necessary private sector beds are expected to be available. Subsequently as VA capacity and demand for VA hospital care come into alignment, private sector bed availability is expected to diminish due to aging in the non-veteran population.

For LTC, where total demand and building costs are not as great as they are for hospitals, projected VA construction levels would coincide closely with demand in all years. Only during the earlier stages of maximum construction (in 1990) and at the peak of demand (in 2010) would there be a shortfall in VA-operated LTC facilities.

Range of Construction Requirements for VA Hospital Beds[1]
(Thousands of Hospital Beds)

Note: Where only one figure is shown, estimates are the same for all projections.

	1990	2000	2010	2020
Estimates of total need	116-189	134-246	128-225	108-188
Recommended Bed Level To Be Met By Construction	85	108-168	108-188	108-188
Gap Between Need and Recommendation	31-104	26-58	20-37	0
Percentage of Need to be Met by Purchase, Lease, or Fee Care	27%-55%	19%-24%	16%	0

[1] Figures represent net operating beds.

For ambulatory care, the strategy would provide VA-operated facilities to meet recommended levels of service in all years under consideration. This assumes the same proportion of VA staff visits vs. fee visits as at present. Meeting real need capacity levels is facilitated because outpatient clinics generally have considerable inherent expansion capacity by such means as extending hours of service or increasing staff. New hospital construction cost projections in this plan provide for outpatient clinics as a necessary part of any VA medical center. The additional construction costs specified for ambulatory care are for the estimated amount of new satellite (freestanding) outpatient clinic capacity necessary. As with hospital and LTC construction, the strategy completes construction of the necessary outpatient clinics by 2000.

D. **Assumptions**

The assumptions underlying this construction strategy are summarized below:

1. VA should plan to build for demand levels that will be sustained over a prolonged period, and thus avoid constructing to meet shorter term demand peaks.
2. To avoid disruptive growth rates, construction to the recommended levels should be concentrated in the 1990-2000 period.
3. Gaps between VA capacity and real need service levels will be filled by leasing and operation of facilities or fee and contract care, as determined during detailed program and facilities planning.
4. Facilities would be constructed by the VA except where less costly alternatives are identified in specific MEDIPP plans and site locations.
5. Specific locations for and numbers of new hospital beds, ambulatory care clinics and nursing home and domiciliary facilities will be determined during subsequent detailed planning efforts.
6. Separate ambulatory care facilities will represent the same proportion of total ambulatory care workload they do now.
7. Construction budget authority will be provided to the level necessary to implement this plan.

Table 3

Range of Estimated Construction Requirements For VA-Operated Beds As Compared With Total Demand For VA-Operated Or Supported Beds (Beds In Thousands)

Note: Where only one figure is shown, estimates are the same for all projections.

	1990	2000	2010	2020
Range of Estimated Need for VA operated or supported LTC beds	66-93	102-131	114-146	103-133
40% of Total Demand (VA-owned target)	27-37	41-52	45-59	41-53
Recommended level to be met by construction	27	41-52	41-53	41-53
Gap to be filled by non-VA constructed capacity	0-10	0	4-6	0
VA-owned beds as a percentage of total demand	29%-41%	40%	36%	40%

8. Approximately 40 percent of the VA long term care beds will be VA-owned and operated, as at present, unless states and communities are unable to maintain their current shares of the total during peak demand growth.
9. The number of domiciliary beds contained in the LTC projection will rise to a ceiling of 11,000 by 2000. This is based on maintaining the current level in Medical Districts which already have domiciliary units, and providing a 200-bed domiciliary unit in each District which does not already have one.
10. For estimating purposes, the cost per bed of each type of facility — hospital, nursing home, or domiciliary beds — is assumed not to depend on location.
11. The current proportion of staff and fee visits in ambulatory care will be maintained.
12. Any new VA hospitals constructed would have ambulatory care capabilities similar to those of existing VA hospitals.
13. Private sector facilities will be utilized mainly through purchase or lease, to supplement VA capacity during the period of VA construction shortfalls.
14. Because of geographical shifts in veteran population, principally from the Snow Belt to the Sun Belt, it will be necessary to construct additional hospital beds during each projection period, beyond those needed to reach "real need" levels. The number of hospital beds which must be constructed to achieve a geographical balance of beds and workload is approximately 3000 and would be constructed between 1990 and 2000. In subsequent decades, while peak hospital demands will have passed, this analysis assumes that smaller numbers of new beds will be necessary to deal with population shifts (1000 beds in 2010 and 500 in 2020). During the decades ending 2010 and 2020, respectively, each projection assumes the same number of additional beds for geographical balancing despite different system sizes. This is because the imbalances will stem from population shifts affecting the 1990 system base of 85,000 beds only. New beds constructed in each of the real need projections would be located in anticipation of population shifts during the plan period.
15. Surplus hospital beds which might result from population shifts would be converted to meet LTC needs whenever facilities were appropriate for conversion and additional LTC nursing home beds were needed in the area. Since the number of beds which can thus be converted must be determined during detailed MEDIPP and facility planning, this construction analysis does not adjust LTC bed construction costs for conversions.

E. **Costing Methodology**

The cost information which follows was derived from recent VA construction experience and is based upon the following:

1. All costs are in fiscal year 1995 dollars.
2. New hospital beds are estimated to cost $245,000/bed for affiliated and $163,000/bed for non-affiliated hospitals.
3. Costs for hospital beds will include the provision of ambulatory care capability and thus the only construction cost associated with meeting the need for increased ambulatory care visits would be that cost of constructing new satellite outpatient clinics. Satellite clinics are estimated to require one gross square foot of space per annual visit at a cost of $143 per gross square foot.
4. The cost for the new VA nursing home care prototype has been used in estimating the cost of new nursing home beds ($6.5 Million/120 bed unit).
5. The cost for providing domiciliary beds is estimated on the basis of a two-hundred bed prototype domiciliary ($8.7 Million/200 bed unit).

Tables 4 through 7 compare the estimated construction costs to provide facilities for each of the workload projections discussed in the aging study at the levels indicated. Table 8 indicates total construction costs and Table 9 identifies a funding strategy by fiscal year to meet the planned levels of beds and outpatient visits.

These costs do not reflect an estimated $10 Billion currently identified to correct deficiencies and meet already scheduled expansion.

F. **General Criteria For Construction Priorities**

The expansion program presented above makes the establishment of priorities for new construction essential. For this purpose, DM&S will develop a system of weighted criteria for ranking construction projects which the Medical Districts propose via the MEDIPP process to meet service need projections. A similar set of criteria will be developed for each major type of facility, i.e., hospital and nursing home. (The Department already has such prioritizing criteria for satellite outpatient clinics.) These criteria will consider each of the following factors, as well as others which prove to be pertinent, in ranking proposed projects.

1. Size of unmet need (in workload terms) that the project would serve.
2. Duration of the need (i.e., for how many years are the workloads necessary for efficient operation of the facility expected to be present)?
3. Availability of alternatives to new construction. Proposals for new construction will receive lower scores on this factor if opportunities to purchase and renovate suitable existing facilities at economical cost exist or if suitable leased facilities could be substituted at reasonable cost.
4. Availability of economical, well-placed site(s).
5. Opportunity to combine replacement of an aging facility with needed expansion.

8. Availability of the health care [illegible] for operate the facility.
7. Whether there is an existing VA medical facility in the area served. Areas with no VA presence would receive a higher score on this variable, to foster equity in the distribution of VA medical care.
8. Climate of community and constituent support for the project. A project for which affected groups who could facilitate project implementation and operation indicate strong support would receive additional weight.
9. Availability of community resources. Communities [illegible] providers would receive greater weight on this variable.

The exact criteria to be used and their relative weights will be decided after careful study and consultation with constituent groups, the Congress, professional and provider organizations, and pertinent Executive Branch agencies. It should be recognized, however, that such criteria alone cannot provide definitive answers, but must be viewed in conjunction with special local considerations and other factors which do not lend themselves to systematic quantification.

Table 4

VA Hospital Bed Needs To Be Met By Construction And Associated Construction Cost ($ Millions)[1]

Projection Method	1990		2000		2010		2020	
	No. Beds	Cost	No. Beds	Cost	No. Beds	Cost	No. Beds	Cost
District	85,000	337.5	108,000	5,175.0	108,000	225.0	108,000	112.5
Metro Area	85,000	337.5	143,000	13,050.0	143,000	225.0	143,000	112.5
Harris Survey-Based	85,000	337.5	188,000	23,175.0	188,000	225.0	188,000	112.5

[1]Exact costs of the construction program will be determined in the MEDIPP implementation process. Costs for all projections during the 2010 and 2020 periods provide for geographical shifts in veteran population, not increases in net bed capacity. Costs in this table are for new and expanded facility construction only. Facility maintenance, modernization, and replacement costs are covered in Appendix III.

Table 5

VA Nursing Home Care Bed Needs To Be Met By Construction And Associated Construction Costs ($ Million)[1]

Projection Method	1990		2000		2010		2020	
	No. Beds	Cost	No. Beds	Cost	No. Beds	Cost	No. Beds	Cost
District	19,000	325.0	30,000	595.8	30,000	0	30,000	0
Metro Area	19,000	325.0	41,000	1,191.7	42,000	52.0	42,000	0
Harris Survey-Based	19,000	325.0	32,000	704.2	34,000	110.5	34,000	0

[1]Exact costs of the construction program will be determined in the MEDIPP implementation process. Costs in this table are for new and expanded facility construction only. Facility maintenance, modernization, and replacement costs are covered in Appendix III.

Table 6

VA Domiciliary Bed Needs and Associated Construction Costs[1] ($ Millions)

Projection Method	1990		2000		2010		2020	
	No. Beds	Cost	No. Beds	Cost	No. Beds	Cost	No. Beds	Cost
District	8,000	26.1	11,000	130.5	11,000	0	11,000	0
Metro Area	8,000	26.1	11,000	130.5	11,000	0	11,000	0
Harris Survey-Based	8,000	26.1	11,000	130.5	11,000	0	11,000	0

[1]Exact cost of the construction program will be determined in the MEDIPP implementation process. Costs in this table are for new and expanded facility construction only. Facility maintenance, modernization, and replacement costs are covered in Appendix III.

Table 7

VA Outpatient Staff Visits Away From VAMC's And Associated Construction Costs For Satellite Clinics
(Visits and Costs In Millions)

Projection Method	1990		2000		2010		2020	
	Visits	Cost	Visits	Cost	Visits	Cost	Visits	Cost
District	3.28	125	3.34	8.6	3.00	0	2.53	0
Metro Area	4.17	253	4.25	11.4	3.80	0	3.21	0
Harris Survey-Based*	3.83	205	4.08	35.7	3.75	0	3.35	0

Exact costs of the construction program will be determined in the MEDIPP implementation process. Costs in this table are for new and expanded facility construction only. Facility maintenance, modernization, and replacement costs are covered in Appendix III.

Table 8

Summary of VA Construction Costs*
For All Real Need Projections
($ Millions)

Projection Method	1990	2000	2010	2020	TOTAL
District	814.6	5,909.9	225.0	112.5	7,062.0
Metro Area	941.6	14,383.6	277.0	112.5	15,714.7
Harris Survey-Based*	893.6	24,045.4	335.5	112.5	25,387.0

Costs are for new and expanded capacity only, and provide for geographical shifts in veteran population which would not result in net additions to bed capacity. Facility maintenance, modernization, and replacement costs are covered in Appendix III.

Table 9

Construction Costs' Potential Funding Strategy

FY	District	Metro	Harris*
1986	39.0	39.0	39.0
87	340.0	368.5	357.7
88	376.5	419.9	404.3
89	684.7	1,651.3	2,711.0
90	684.8	1,651.3	2,711.0
91	656.2	1,625.4	2,717.9
92	664.8	1,594.2	2,664.7
93	664.8	1,605.6	2,700.4
94	656.2	1,594.2	2,664.7
95	656.2	1,594.2	2,664.7
96	647.5	1,585.5	2,656.0
97	651.8	1,596.3	2,647.3
98			
99			
2000			
1	45.0	45.0	64.5
2	45.0	58.0	64.5
3	45.0	58.0	64.5
4	45.0	58.0	64.5
5	45.0	58.0	64.5
6			13.0
7			
8			
9			
2010			
2011	37.5	37.5	37.5
2012	37.5	37.5	37.5
2013	37.5	37.5	37.5

Funding for new and expansion construction to project levels will be completed by 2013.

*Note: The Harris Survey is a public opinion poll. As such, the requirements identified in that survey can only be justified in the context of the survey.

Demand for Care Exceeds VA Resources

[From the American Medical News, Dec. 21, 1984]

(By Phyllis Capen)

For U.S. men and women who carried the red, white, and blue into battle against their country's enemies, Veterans Administration (VA) health care is a precious commodity. When personal finances dwindle and other sources of medical care run dry, former soldiers often use the VA as a safety net.

A staggering four million veterans of World War II, Korea, and Vietnam are obtaining medical treatment annually at VA facilities, according to a recent VA report, "Caring for the Elderly Veteran" (*AMN*, July 27, 1984). Within 15 years, another five million veterans are expected to be added to the VA's patient population as some 11 million surviving World War II veterans reach 65 and become eligible for VA care.

The projected influx of ex-soldiers threatens to swamp the VA, even though the $9.1-billion health arm of the agency operates the nation's largest hospital network and has a budget that is larger than that of the Dept. of the Interior or the Dept. of Commerce. Within six years, Congressional Budget Office (CBO) economists estimated, the VA will need 85% more cash to meet the increased demand for medical care. A total of $15.4 billion could be required, they predicted. VA staff have estimated that the cost of providing treatment could even be as high as $18 billion in 1990.

Projected supply and demand problems already have proven to be more than theory. "The escalation of the demand for care is already exceeding the ability of the VA to deliver it," said Bob Lyngh, a national director of the 6.5 million-member American Legion. He said problems were cropping up among patients who needed chronic care. The first proof of a shortage of VA health services emerged last January when an agency audit showed that the VA quietly was grappling with an increasing demand for services by monthly turning away up to 20,000 eligible patients. Knowledgeable observers said they saw this patient care dilemma as the symptom of an underlying condition [illegible] either would stimulate the growth [illegible] development of effective preventive an[illegible] long-term care strategies for elderly Americans or stymie innovative geriatric programs being undertaken within the VA.

The two-million member Veterans of Foreign Wars (VFW) said it had been receiving hundreds of complaints monthly from veterans denied treatment at the VA's 172 medical centers. "I wouldn't call it a small problem," a veterans service organization official said.

ACCORDING TO the American Legion, veterans injured in the course of serving their country are getting the VA's free, comprehensive care, but those with so-called non-service-connected problems sometimes are being turned away because they are entitled only to the care the VA can supply under congressionally

approved prospective budgets. When VA hospital balance sheets threaten to go into the red, institutions reject patients labeled as non-service-connected veterans representatives explained. "Non-service-connected veterans are being turned away in droves," said Cooper Holt, executive director of the Washington, D.C. VFW office.

"It's the World War II veterans who are reporting the problems obtaining medical treatment," Lyngh explained. "For the most part they are elderly persons with chronic conditions, such as arthritis or heart disease, which require management and regular medication.

Choosing which patients to turn away presents a nightmarish dilemma for the VA because its population of non-service-connected patients is so large. Last year the CBO reported that as much as 80% of VA medical services were going to veterans with non-service-connected disabilities. Thus far, Lyngh said, the VA appears to be softening the impact of its belt-tightening by limiting the total amount of care granted to individual patients. "Veterans are not so much being denied care as [they are] the amount of care they need," he said in an interview with AMA. "The VA is caring for patients to the point of stabilizing their condition and then is referring them to community facilities."

If a patient with diabetes is admitted to a VA hospital, staff could treat the diabetes, prescribe a limited amount of medication, and schedule several follow-up visits, Lyngh said. After that, however, the aging veteran would have to finance his care through private insurers, Medicaid, Medicare, or out-of-pocket expenditures. In many cases the VA's cost-shifting strategy works well for the agency and its patients. The strategy sometimes backfires, however, and medically indigent patients have to be rehospitalized.

"A lot of VA patients," Holt said, "are living on Social Security" and can't afford to obtain private health care when they leave the VA. "The veteran does nothing [does not get outpatient care]; consequently his health gets worse."

When the VA alters its continuum of care to stay within its budget, it attempts to avoid stimulating higher demand for medical care and greater overall costs, but it is difficult to predict the outcome of changes in health care policy. "While you think you may be saving money in one area, you have to be sure that in the cost transfer you aren't really costing it out in another area," warned the VA's new chief medical director, John W. Ditzler, MD, in an interview.

THIS PARADOX is critically important to Congress this year because there is mounting dissatisfaction over veterans who are entitled to Medicare and more comprehensive VA care. Sources said policy-makers were reconsidering eligibility rules for former fighting forces who were insured doubly. Whether it is cheaper to treat non-service-connected disabilities or illnesses under Medicare or through the VA is a key issue being weighed. VA costs are skewed upward because of long-term care patients who allegedly have no private-sector counterpart. Among them are some 2,500 veterans with spinal cord injuries who are receiving lifetime care.

Shirley Wester, executive director, American Health Planning Assn., said she was painfully aware of the effect that a change in one federal health program — like the VA — has on another. "The trouble with the health care system," she said, "is that it is like a balloon. Push it in one place and it enlarges in another."

Internal VA reports show that increasing Medicare co-payments designed to dampen health care demand among the elderly actually have prompted more ex-soldiers to seek VA health care in 1984. There is a danger that health economies among VA chronic care patients could balloon the demand for acute care under Medicaid because veterans who turn to the VA often have multiple health problems, insufficient insurance, little or no family support, poor income, and an inability to pay for follow-up care. "The last thing states and counties want at this point is to have to absorb any part of the responsibility currently seen as belonging to the VA," Wester said.

In the years ahead, one of the knottiest health policy issues to face the VA will be its management of veterans 75 and older. Among the nation's World War I and II fighting forces, those 75 and older consume the greatest amount of medical care, using up much of it for nursing home services. Only one million nursing home beds exist in the United States, but within 15 years there will be four million veterans 75 and older. The recent VA report on caring for veterans outlined how VA staff proposed to contain health care costs, hold down demand, and increase the quality of life among these heavy users of VA health care and other veterans. The lofty goals are to be accomplished by training VA staff to identify treatable geriatric illnesses in their early stages, finding new ways to prevent and treat problems among the elderly, and using health care teams to keep aged veterans in their own homes as long as possible.

Before the report was made public, Office of Management and Budget officials accused VA staff of producing a document that read like a Dept. of Defense "maximum weapons list." The White House pressured the agency to lower some of its original need projections, but VA staff still maintain that their strategies can improve the health of aging veterans and lead to a lower national health bill.

THE CHALLENGE of attempting to prevent disease among the elderly is that there is no infrastructure in the U.S. health system to support such an endeavor. VA staff proposed creating the machinery to do so within the VA by conducting geriatric research, training clinicians, developing geriatric clinical centers, and instituting home health and day care programs for elderly Americans. Health care needs would have to justify the cost of implementing new programs, but it is difficult to project health care demand accurately in a population as diverse as U.S. veterans. Dr. Ditzler said one of the largest issues his agency would face was uncertainty about the number of veterans who actually would turn to the VA.

"The presumption is that since Americans are getting older, veterans — while getting older too — may also be consuming more medical care," Dr. Ditzler said. "The big problem is that there is a vast reservoir of some 28 million veterans out there now, but in any one given year we don't begin to service that many veterans. If there is a change in the number of veterans we care for, then we have to match the resources against whatever the expanding population is," he explained.

Only 20% of eligible veterans use VA services, but a Louis Harris poll of 3,000 55-year-old veterans indicated that many more of them intended to turn to the VA in the future. CBO economists said they expected only 25% of veterans to ask the VA care, but VA staff said they thought it

To meet the growing demand the VA staff report proposed increasing VA personnel by 70% within 15 years, doubling the amount of geriatric training for VA employees by 1990, adding 68% more VA hospital beds by the end of the century, raising the VA's construction program from $1.3 4 billion to up to $25 billion between 1990 and 2000, and augmenting the number of VA-operated or-contracted nursing homes by 175% in the next 25 years.

Already controversial with the Reagan Administration because it proposed increases in the size and cost of government, "Caring for the Older Veteran" reportedly irritated presidential advisers by also asking for a 58% increase in VA acute care capacity, a 36% rise in ambulatory care, and a 50% growth in nursing home capacity. Only 15,000 independent veterans will use the VA's adult day care, hospital-based home care, and outpatient psychiatric care services in 1985, but VA staff estimated that 760,000 would need it within 15 years. VA analysts also wanted more geriatric clinical centers — 22 in the next six years — at which to evaluate veterans. The cost of implementing this strategic health care plan would require doubling the VA's health budget (to $18 billion) by the year 2000.

ANOTHER SOLUTION to the dilemma aging veterans present is to transfer some of the VA's responsibilities to other segments of the health care system, a strategy the Reagan Administration has advocated. Immediately after the presidential election, the Reagan Administration announced that it was considering cutting veterans' medical benefits.

The most important shift — both politically and economically — would be trimming benefits for non-service-connected VA patients, a move that CBO analysts said would save more money than any other cost-cutting option open to the federal government. The Administration also proposed making VA benefits contingent upon financial need, collecting co-payments for medical services, rescinding increases in the VA's medical budget, and restraining new geriatric programs for veterans who need not be in institutions. The Administration, moreover, has advocated cutting back plans for VA nursing homes and hospitals and contracting privately for support and medical services.

Veterans service organizations expressed strong feelings about cutting VA health services. The VFW's Holt predicted "all hell would tear loose on Congress." If the Administration seriously sought to eliminate non-service-connected medical care.

AMERICAN LEGION officials said transferring the responsibility for veterans' care from the government to the private sector was objectionable. "Our experience and our perception of the private sector is that they will not bring to the care of veterans the dedication, the efficiency, and the concern that we now get from the Veterans Administration," Lyngh said. "The American Legion will oppose any effort to either reduce the VA system in size or [to] dismantle it."

Holt asserted that veterans service organizations carried enough political clout in Congress to stave off changes in VA entitlements. "The President proposes, but Congress disposes," Holt emphasized. "I don't think Congress is in a mood to eliminate veterans' care."

Donald Custin, MD, medical director of the Paralyzed Veterans of America (PVA) and former VA chief medical director, maintains that the political climate in Congress may not be as favorable for veterans as it has been in the past because of the huge deficit the country faces. "The country has never been in quite this shape before in terms of that deficit," Dr. Custin said in an interview with *AMN*.

"There's little in the immediate future that can be addressed in the way of further cutbacks that can match the possibilities of cutting back on health services. I would imagine that we've reached a time when Congress is indeed going to take a hard look at a redesign of health policy," he said.

"If you have a good way of identifying the needy veteran, I think a lot of the criticisms of the VA would disappear. I think [that] fundamentally, the electorate is generally in favor of veterans and veterans' benefits, but not to [the point] where it's unnecessary and it's wasteful. There certainly is going to have to be much more accountability than there's ever been before."

VA INSIDER Dr. Ditzler, when asked whether he was uncomfortable about the possibility of turning veterans away from VA hospitals and nursing homes, said: "I am uncomfortable to the degree that the law requires that I provide care to certain eligible veterans. Therefore, I think if the law requires *me* to provide that care that I will get the resources to provide that care. If it is in the wisdom of the people's representatives to change that, then I think they need to change or more clearly define the eligibility."

A word that touches a raw nerve with the American Legion, the PVA, the VFW, and the Disabled American Veterans is "mainstreaming." In its purest form it means that veterans would use a medical voucher to obtain care privately or that medical services would be contracted for outside of the VA, as the Reagan Administration has proposed. "The American Legion is categorically opposed to that concept," Lyngh said. "We believe the present system as it is presently established and administered by the VA is the best system to provide this benefit."

"If mainstreaming were ever instituted," Holt said, "veterans might as well give up the program. The American Medical Association and the American Hospital Assn. want the government to bail them out. It's not our fault they overbuilt."

Dr. Custin, who has a reputation for being politically astute, said he "wouldn't be surprised but what there will be consideration given to vouchering for veterans' care. No matter how you look at it, the VA simply can't expect the resources that it's going to take to accommodate the huge numbers of aging veterans that are just a few years ahead."

The VA's harshest critics contend that health care vouchers will decrease the administrative costs of VA medicine, eliminate the need for new VA facilities in communities with too many hospitals, and enable many veterans to obtain care closer to home. Ten percent of the VA's health care dollars already are going to private contractors in regions where there is a dearth of technical expertise or VA facilities. Contracting out more care might work, Dr. Custin said, if the VA were "able to control the purchase of care in the private sector." The danger is that high demand for acute care patients would erode VA programs, leaving behind underused VA hospitals and costly long-term care patients.

AS FOR THE issue of VA/private physician competition, AMA trustee John Ring, MD, said he perceived "no groundswell on the part of doctors saying we should get a piece of the VA action." In 1982 the AMA took the position that "every individual injured or diseased as a proximate result of service in the uniformed services of the United States should have, as a matter of right, the health care he needs and desires paid for by the people of the United States" and that "all persons who have served in the uniformed services who need medical care and who cannot themselves pay for it should have access to appropriate care, paid for by the people of the United States."

Attending to the health and welfare of America's soldiers has been a historic concern in the United States. Even before the Declaration of Independence was signed, the country's forefathers had been deliberating over a pension system for injured and disabled soldiers and over whether to grant half-pay service pensions to retired Revolutionary War officers who had fought through the end of the long insurrection. In making their decision, the Founding Fathers followed the example of their English progenitors. In 1588 the English established a system for compensating wounded fighting men of the realm; on Aug. 26, 1776, the Americans followed their lead. George Washington contended that attending to all of the veterans' needs was the price of freedom.

While arguing for half-pay for loyal officers, he said the payments "should not be regarded in the odious light of a pension, but as a reasonable compensation for valuable service, when Congress had nothing else to give. It was the only means to prevent a total desertion of the service . . . It was the price of their blood, and of your independency; it is a debt honor; it can never be considered as a pension or gratuity." Americans responded by paying out $70 million worth of pension benefits to Revolutionary War veterans.

How Congress chooses to resolve the VA's dilemmas — whether it be by preparing for a deluge of patients or by passing responsibility for the patients onto overburdened state health programs and Medicare — is important to the health sector as a whole. Veterans are aging faster than the rest of the population and what happens to them will affect the future of even larger segments of the population who just now are beginning to count gray hairs.

3/M

City of Bayou La Batre
M.G. TEMME, MAYOR
BAYOU LA BATRE, ALABAMA 36509

COUNCIL MEMBERS
TOM LAMEY
ARLEN LYONS
J.F. (Jiggs) NELSON
LEVERNE SIMMONS
ROBERT I. WEST

March 13, 1985

Honorable John M. Tyson
600 Bel Air Blvd
Suite 210
Mobile, Alabama 36606

Dear Mr. Tyson,

As Mayor of the City of Bayou La Batre, I wish to express my support for the V A Hospital you are trying to attain for this area. We have many residents of our City and the surrounding area who have to travel many miles in order to have treatment at a V A Facility. We feel the hospital in Mobile is in an area that has enough veterans that we would certainly have the right to ask for this hospital.

Please feel free to express my support and the support of the Councilmembers of the City of Bayou La Batre for your endeavor on our behalf.

Sincerely,

M. G. Temme Sr.

M. G. Temme, Sr., Mayor

JRH

V F W VETERANS OF FOREIGN WARS OF THE UNITED STATES

ALL AMERICAN COMMANDER

PAGE 1

ROBERT A. BOSARGE
Post Commander, Alabama
1981-82

The drive started in May 1976 when the grave factor became aware that the vetern numbers were growing at alarming rates in the District Nine V.F.W. Area. In 76 77 78 and 79 I Was Adjutant for Post 49 Mobile. Also I served as SR Vice Cmdr and Planning Officer for the American Legoin Post 250. It was my job (and by the way) it started as a two day one, to end up a seven day job as it still stands today as Service Office Payne can submit. To releive the gross over flow of the Veteran care and neglect of Hospital space that was and is still the main factor today as why we are all here. I am going to lay out the plan on the Vetern Of Foreign Wars only, but please keep in mind that this also bears on the American Legoin, Disabled American Vetertans, And the Association of Prisoners Of War. We started seriving Baldwain And Mobile counties as we have 15 VFW Posts and for the record out of 10,000 posts world wide one post alone 49 Mobile is the largest post in the world. It alone has stood with over 3 thousand members and still leads the top.
A van was brought by myself with approval from the membership of the Veterans to start carring sick and needy to Biloxi. Also the other 14 service officers were running at a pace of one to three times a week. IN 1978 it was seen that this was not enough of help to even dent the problem. We started and won approval which still stands today to have an VA outpatent clinic plaaced in Mobile along with the regular North Mobile one already busting at theseams and turnng away Veterans as it does on a daily basis even today at an alarming rate.
In 80 81 82 83 I came through all the chairs learning more and more of this hard core factor that grew every day. For the past nine years since retiring out of the Navy in 76 I have fought on all levels the gain releif are some kind of happy medimiun to ease the ever growing negelect of our American Veteran. Congressman SHELBY in 82 83 and 84 I have been National Aide De Camp to the National commander In Chief as I am today. As all American Commander of the world in 81 and 82 and Young Veteran of the year in 82 83 at the utmost levels again I was fighting for us. As District Nine Commander in 83 and 84 I really learned of the largest and most grave problem in watching it grew over the past nine years right here in my on home area. All the past years the finger kept pointing to this ever growing swell of medical need as the Veteran populatin swelled to record levels right here.
A break down as fllows will lighten the factor . Since 76 District 9 has grown at an alarming rate of over 161 per cent per year, this is all on National Record and filed with the Commander In Chief. As You also know the V.F.W. just surpassed the highest level in the history of its bening in 1985 and Alabama lead the way By Commanber Tommy Richardson making All American Alabama Commander. Over 2 Million VFW veterns are on record and here in Mobile alone we lead the WORLD VFW Records as having the all time voting count of 493 votes, which means the leading concertration of veterans in one Area. (Please remember these are only the veterans out of the 124000 in the Area that served in combat only and can belong to the VFW.) As I said the other (American Legion) DAV and POWs are all in the same Field of facts, and even more so because they have access to more members.
To sum all this up nine years ago we started out with one van and seven cars in two counties, MOBILE & BALDWIN. Today on the road we have 26 vans and over 62 private autos hauling veternas to biloxi and gulfport ever week. WE now serve Washington, Escambina Clarke,Monroe,Choctaw Butler and Conecuh Counties in Alabama. We have hauled vets out of Escambia,Santa Rosia, Holems, Okaloosa and Walton counties in Florida. In Mississippi we have picked up vets in Jackson, George, Greene, Harrision, Stone, and Hancock counties.
In checking service officer records nine to 17 vets were turned away a week showing in

V F W VETERANS OF FOREIGN WARS OF THE UNITED STATES

ALL AMERICAN COMMANDER

ROBERT A. BOSARGE
Post Commander, Alabama
1981-82

in 1976 and 77. Today that has grown to 31 to 73 that can not get Medical services as they need are surely entilled to. Inclosed in this report is the Natoinal count of the Alabama V.F.W. showing the south end or lower L.A. (lower alabama) District 9 with the largest count nation wide only to Evans Ville Indiaina. There are 165 VFW Posts in the northern part of our state. This makes up all in all to only 54 per cent of vets throughout the rest of the state. The southern counties of Moible and Baldwin carry 46.9 percent of the satet VFW membership. Also along with this report is a copy of the preparied (V.A.) not ours report on the VFW (VA) clinic from VA biloxi Assigned to Post 49 Every month. There are only 14 Posts in the south end of the state to have the VA approve and conduct this large factor for no other post out of 10000 world wide has its own VA approved clinic. For the past 9 yeasrs we have needed the hosiptal as it has and will be proved in this hearing along with all of the pure ground evedince today and in the past

R.A. BOSARGE
State B.P. Chairman
VFW Alabama

D-7 Cdr. Hobbs	10-1-84	1985	1984
1280 Elba	16	62.1	29
3073 Dothan	392(102)	48.6	806
3548 Samson	2(2)	8.0	25
4426 Slocomb	31(2)	58.5	53
4448 Ozark	87(12)	41.6	209
4942 Troy	3(3)	9.4	32
5850 Eufaula	138(70)	53.5	258
6020 Daleville	299(126)	51.2	584
6224 Abbeville	26	104.0	25
6683 Enterprise	42(8)	52.5	80
6839 Geneva	00	0.0	27
7513 Hartford	31(6)	40.3	77
8039 Clio	6	24.0	25
8524 Ashford	1(1)	1.3	80
9352 Columbia	6	24.0	25
Total	1080	46.3	2335

D-8 Cdr. Wise			
3454 Andalusia	35(6)	35.0	100
3581 Evergreen	15	60.0	24
3625 Greenville	00	0.0	28
4388 Red Level	34	59.6	57
4960 Covington Co.	20(1)	36.4	55
5524 Atmore	12(1)	37.5	32
6329 Brewton	8	25.0	32
6618 Florala	53(2)	55.2	96
6620 Brantley	15	60.0	23
6622 Opp	89(27)	47.1	189
6961 Flomaton	18	62.1	29
8485 Monroeville	00	0.0	57
9508 Dozier	24(1)	63.2	38
9553 Luverne	15	45.5	33
9554 Georgiana	24(2)	66.7	36
Total	362	43.7	829

D-9 Cdr. Brown			
49 Mobile	1322(471)	48.8	2709
3550 Whistler	29(6)	18.2	159
3568 Bay Minette	154(35)	46.2	333
4328 Spanish Fort	68(24)	28.0	243
4648 Gulf Shores	31(4)	47.7	65
5226 Robertsdale	83(41)	52.2	159
5526 Bayou La Batre	8(8)	7.3	109
5528 Prichard	5(5)	6.6	76
5658 Elberta	275(118)	59.5	462
5660 Fairhope	163(60)	56.0	291
6244 Grand Bay	18	50.0	36
7320 Saraland	201(75)	60.7	331
9341 Citronelle	7(1)	28.0	21
10274 Mt. Vernon	0	0.0	24
Total	2364	46.9	5036

D-10 Cdr. Myers	10-1-84	1985	1984
3016 Selma	272(125)	44.0	550
3223 Butler	32(1)	47.8	67
4470 Uniontown	31	34.1	91
5030 Demopolis	25(3)	64.1	39
5104 Marion	59(6)	48.4	122
5106 Thomasville	6	24.0	19
5355 Jackson	91(15)	49.5	184
5377 Linden	75(8)	80.0	94
5552 Chatom	3	12.0	22
5848 Lisman	10	38.5	26
10261 Jackson	22	84.6	26
10371 Camden	7	26.9	26
10504 Pine Hill	6	24.0	19
Total	639	49.7	1285

D-11 Cdr. Savage			
2625 Tuscaloosa	68(5)	47.9	142
4650 Sulligent	39(1)	59.1	66
4767 Aliceville	35(4)	41.7	84
4923 Centreville	6(1)	24.0	17
5375 Eutaw	9	36.0	16
5406 Fayette	27(2)	45.8	59
5568 Reform	28(5)	66.7	42
6022 S. T'Loosa	186(32)	49.3	377
6171 Greensboro	13	52.0	14
8610 Gordo	12(1)	48.0	23
8656 Sumter Co.	16	64.0	18
10412 W. Blocton	5(1)	20.0	18
Total	444	50.3	883

D-12 Cdr. Roden			
4348 Addison	1(1)	4.0	14
4529 E. Walker	55(6)	61.1	90
4543 Haleyville	49(13)	35.5	138
4850 Jasper	271(59)	41.0	663
4919 Sheffield	415(89)	50.2	826
5140 Florence	132(19)	44.3	298
5184 Russellville	39(1)	54.2	72
5503 Winfield	00	0.0	23
5846 Rogersville	34(1)	58.6	58
6567 Moulton	12	42.9	28
6685 Guin	10	40.0	25
7304 Cherokee	12(2)	48.0	22
7391 Hamilton	25(1)	35.2	71
8212 Carbon Hill	16(1)	64.0	25
8362 Town Creek	31	47.0	66
8603 Cordova	87(29)	58.0	150
8604 Lynn	11(1)	44.0	20
8640 Sheffield	30	50.0	60
9556 Hackleburg	17(3)	63.0	27
10392 Oakman	19	44.2	43
Total	1266	46.6	2719

Members At Large 22(5)

*An Asterick by your post indicates Quota Buster

This report reflects Life Members

STATE OF ALABAMA

10-1-84 - 14,466 - 51.64%----------Ahead - 560 Members-----Goal for 10-31-84 - 70% - Need 5144

D-1 Cdr. Clem	10-1-84	1985	1984
2214 Cullman	95(27)	46.1	206
2702 Huntsville	801(169)	66.0	1214
2739 Grant	89(30)	62.7	142
4190 Decatur	349(84)	45.6	766
4533 Albertville	20(2)	50.0	40
4765 Athens	222(26)	70.7	314
5173 Guntersville	75(10)	75.8	99
6073 Scottsboro	119(20)	44.2	269
6226 Arab	38(2)	76.0	50
6837 Boaz	177(40)	64.6	274
8654 Decatur	00	0.0	10
8669 Huntsville	59	67.0	88
9567 New Hope	3(3)	2.5	120
10495 Stevenson	2(1)	8.0	14
10503 Madison	1(1)	4.0	14
Total	2050	56.6	3620

D-2 Cdr. Burke			
2760 Gadsden	440(86)	50.2	876
3128 Ft. Payne	290(93)	50.2	578
3229 Springville	30(1)	40.0	75
4391 Collinsville	42(2)	67.2	64
4645 Oneonta	8	32.0	22
4652 Centre	12	42.9	28
4758 Pell City	35(3)	47.3	74
5624 Snead	48(3)	68.6	70
6652 Ragland	34(3)	25.8	132
8140 Gadsden	12	31.6	38
8188 Steele	33	73.3	45
8454 Attalla	21	53.8	39
8600 Gadsden	400(117)	67.5	593
8601 Blountsville	4	16.0	15
9882 Crossville	14(1)	24.1	58
10370 Rainsville	175(38)	51.9	337
10408 Glencoe	46(3)	97.9	47
10409 Hokes Bluff	37	56.1	66
10494 Cedar Bluff	00	0.0	19
Total	1681	52.9	3177

D-3 Cdr. Campanotta			
668 Birmingham	552(113)	49.5	1115
1762 Bessemer	185(41)	75.2	246
3407 Ensley	193(43)	51.6	374
3492 Fairfield	450(129)	54.7	822
3565 East End	26(9)	61.9	42
4492 Warrior	60	85.7	70
4494 Tarrant	1(1)	4.0	20
4921 Shelby Co.	00	0.0	24
5963 Alabaster	41(3)	33.1	124
6173 Brookside	104(42)	58.1	179
6440 Leeds	44(8)	73.3	60
8026 Bessemer	73	100.0	73
8361 Montevallo	11	44.0	14

D-3 Con't	10-1-84	1985	1984
8432 Pinson	17	45.9	37
8479 Brighton	6	24.0	15
9572 Warrior River	19(1)	38.8	49
10250 Gardendale	18	48.6	37
10360 Irondale	53(16)	56.4	94
10439 Montevallo	11	44.0	15
Total	1864	54.7	3410

D-4 Cdr. Shell			
924 Anniston	509(143)	54.7	930
3215 Ashland	10(1)	40.0	20
4261 Talladega	175(9)	65.8	266
4263 Piedmont	170(23)	66.9	254
4432 Sylacauga	6(1)	24.0	13
4623 Heflin	28(16)	53.8	52
4638 Anniston	28	73.7	38
6565 Goodwater	4	16.0	17
6571 Wedowee	79(5)	69.9	113
9581 Lineville	41(28)	46.6	88
10411 Wadley	8(4)	28.6	28
10497 Childersburg	00	0.0	26
Total	1058	57.3	1848

D-5 Cdr. House			
1701 Alex City	199(28)	57.7	345
3212 Fairfax	6	12.0	50
4545 Tuskegee	12(4)	48.0	19
4749 Opelika	10(1)	40.0	24
5035 E. Tallassee	57(12)	38.0	150
5180 Ft. Mitchell	16(4)	34.8	46
5228 Smiths	69(9)	43.4	159
5310 Tuskegee	88(20)	81.5	108
5345 Bullock Co.	11(1)	44.0	25
5404 Auburn	191(58)	53.8	355
5566 Dadeville	184(23)	86.0	214
5732 Opelika	51(2)	28.2	181
5797 Phenix City*	115(12)	132.2	87
7994 Phenix City	158(6)	99.4	159
8602 Valley	8	25.0	32
9884 LaFayette	31(1)	64.6	48
Total	1206	60.2	2002

D-6 Cdr. Phaup			
96 Montgomery	277(45)	63.2	438
3193 Clanton	13	50.0	26
4176 Montgomery	32(16)	62.7	51
4572 Wetumpka	33(3)	24.8	133
6331 Maplesville	5	20.0	15
8711 Millbrook	1(1)	4.0	17
9542 Ft. Deposit	21	84.0	21
10366 Montgomery	22(13)	47.8	46
10422 Jemison	26(1)	59.1	44
Total	430	53.3	807

This report reflects Life Members

*An Asterick by your posts indicates Quota Buster

MOBILE VFW TRAVEL TEAM EVALUATION

November 1983 - October 1984

The Mobile VFW Travel Team Program continued during 1983-1984 with no changes in the staffing pattern. The staff includes two psychiatrists, two social workers, one R.N., one psychologist and one MAS clerk. Generally, the same two psychiatrists attend, Dr. Wm. Wood and Dr. E. J. Stathacos; two social workers attend regularly, Bill McCaughan or Ralph Scott (the second social worker each trip is assigned on a rotating basis); Mrs. G. Dawson is the regularly assigned R.N. and Dr. E. Shatus is the psychologist attending regularly. Currently, Jim Plutino, MAS, handles the arrangements for the trip itself, including preparation of records, scheduling, consults, etc.

Veterans and their families attending the Clinic have expressed considerable satisfaction with the team members. They are particularly pleased at having the same team members work with them on a regular basis. Several team members have made at least 70 of the total 77 trips to Mobile since June 1978, when the program began (Dr. Wood, Mrs. Dawson, Dr. Shatus).

Since the program was initiated in June 1978, the travel team has seen a total of 3,444 outpatient veterans who live in the area served by the VFW Clinic. For this 77 month period, an average of 45 veterans (many with family members) have been seen each month. The number of veterans seen has increased gradually over the seven years of the program. According to the most recent data, 1983-1984, the team members see an average of 51 veterans each month at the clinic.

(8 Pages) report.

NUMBER OF VETERANS SEEN IN MOBILE BY TRAVEL TEAM

	1978	1979	1980	1981	1982	1983	1984
January		35*	38	43	53	60	54
February		65*	33	40	54	60	50
March		24	39	46	62	42	52
April		50	38	41	42	50	52
May		21	36*	50	50	53	47
June	40	48	40	47	50	49	70
July	37*	25	43	46	43	54	33
August	37*	40	41	59	34	36	55
September	35	33	44	70	44	57	57
October	37*	27	48	53	37	49	42
November	37*	36	38	35	46	48	--
December	37*	41	58	48	31	49	--
=	260	445	496	578	546	607	512
$\bar{X}$ =	37	37	41	48	46	51	51

* = estimated from staff notes or average

GRAND TOTAL VETERANS SEEN = 3,444

TOTAL Number of Visits = 77

Average #Veterans seen each trip = 45

OUTPATIENT SATISFACTION SURVEY

An outpatient satisfaction survey was made available to the veterans at the clinic for the September 1984 visit. In earlier years this same survey form was used. Previously veterans were asked to complete the survey on the basis of randomly selected last digit social security numbers. Some veterans had expressed anxiety in responding to the survey itself however. This year a different system was used. Twenty forms were prepared and the psychologist announced to the large group that a satisfaction survey questionnaire was available. Surveys were handed out to those veterans requesting them. In two cases, veterans were openly aggressive in demanding a questionnaire. They were given the survey to complete. There are some differences but the overall impression is similar to that previously reported.

Total number available = 20

Total number returned = 16

Sex = 16 male

Race = 8 white
6 black
2 no information

Age = Less than 35 = 4
35-44 = 5
45-54 = 2
55-64 = 2
65+ = 1
no info = 2

Military Service Time: Viet Nam Era = 9
Post-Korea = 1
WW-II = 1
No info = 5

Survey questions 1-5 relate to waiting room facilities and comfort. The Mobile VFW Chapter donates space, coffee, cakes, etc., for the clinic use. For questions 6-24, the percent of yes-no responses was as follows:

		Yes	No
6.	When you came in did you have to wait too long before you received attention?	19%	81%
7.	Did you have trouble finding the right place to go?	0%	100%
8.	Have you been told enough about your condition?	44%	56%
9.	Are you satisfied with the care you are getting?	87%	13%
10.	Do you think that you would be getting better care if you went to a private source?	12%	88%
11.	Did you have to wait anywhere for a long while without anyone giving you a good reason?	12%	88%
12.	Did the people on your case try to understand how you felt about your health problems?	69%	31%
13.	Did the treatment staff act like they were doing you a favor by treating you?	33%	67%
14.	Do you think that your VA doctor relies too much on drugs and pills?	19%	81%
15.	Was the treatment staff concerned only with your disease but had no feeling for you as a person?	25%	75%
16.	Does the treatment staff really know what is wrong with you?	69%	31%
17.	Does the treatment staff take a real interest in you?	81%	19%
18.	Did you have any difficulty communicating with your VA doctor because of his language problem?	19%	81%
19.	Was anyone crabby?	12%	88%
20.	Were most people friendly?	94%	6%
21.	Was anyone rude?	6%	94%
22.	Were most people?	100%	0%
23.	Was anyone not interested?	13%	87%
24.	Were most people considerate?	94%	6%

Survey results are interesting to examine from several points of view. First of all, as noted, a high percentage of the respondents were relatively young Vietnam veterans (56%). Several respondents demanded survey forms, clearly not the usual procedure. Even under these conditions, results are generally consistent with previous years and indicate satisfaction with the program. Specifically, 87% indicate satisfaction with the care they are getting (Q.9); only 12% thought they would be getting better care if they went to a private source (q 10); 81% indicated they felt the treatment staff really takes an interest in them (Q 17).

Another interesting observation is that the respondents indicate that 19% of them (3 cases) had difficulty communicating with their VA doctor because of his "language problem". But, both psychiatrists and the psychologist on the team are native-born Americans, from the South, with no language problems. One possible explanation is that the veterans may be expressing concern about the recent change to the use of generic medications. Although this change was explained to the veterans, many expressed anxiety when these medications arrived in the mail looking different and labeled different.

Another observation regarding the overall results of the survey was that usually the respondents complete the survey throughout this morning while waiting to be seen at the clinic. On this day, most forms were completed in a very short time. Some veterans completed their questionnaire before being processed by the MAS clerk.

Finally, this survey included a high percentage of respondents who were observed to be rather vocal in their demands. It appears they tend to be vocal about the VA "system" in expressing themselves, somewhat inconsistent in what they say, but overall, not dissatisfied with the treatment.

OUTPATIENT READMISSION SURVEY

After the team visit to Mobile on September 5, 1984, the 57 outpatient records taken to this clinic were reviewed as to whether the veteran had been readmitted to the Psychiatry Service at Gulfport within the last year. Of the 57 records checked, 16 veterans had been readmitted to a psychiatric ward from outpatient status with the VFW travel team during this period. This is a 28% admission rate. At the same time, medical Information Service collected data to determine the readmission rate to Psychiatry Service at Gulfport (Wards B, D, F, & G) for September 1984. Medical Information Service reported 65 readmissions out of a total of 103 admissions to Psychiatry Service for the month. This is a 63% readmission rate.

A Chi square test was done to check for significance between the different readmission rates. Results indicate significance beyond the .001 level. This means the difference between the readmission rates occurred less than one time out of a thousand by chance alone (Chi square = 18.02 $p < .001$; df = 1). These results are consistent with those previously reported.

READMISSION RATE SUMMARY TABLE

Report Date	VFW Clinic	Gulfport Psychiatry Svc.
1980	6%	56%
1981	18%	59%
1982	24%	58%
1983	17%	61%
1984	28%	63%

FISCAL COMPARISONS

The estimated cost of the VFW program in Mobile is approximately $15,000 per year. This includes staff salary and cost of travel for the 12 trips (Fiscal Service, 1983 data). In 1983 the travel team served 607 veterans at the VFW clinic in Mobile. The cost for this service therefore was less than $25.00 per veteran per visit. As reported last year, based on the average cost of hospitalization at the Gulfport Division, if only three veterans are maintained out of the hospital by the VFW clinic in a year, the program will have paid for itself for the year. With costs of hospitalization rising this is a small price to pay for a program that has consistently demonstrated effectiveness in maintaining veterans within their home and community--out of the hospital.

SUMMARY

Since beginning June 1978, the Mobile VFW travel team has traveled to Mobile each month to serve the Mobile area veterans and their families in an outpatient psychiatric clinic. The number of veterans served each month has increased to where we now see an average of 51 veterans per month (1984). Readmission rates for the VFW program and for the Psychiatry Service at the Gulfport Division have been compared statistically for each year. Consistently the VFW clinic readmission rates have been significantly lower ($p < .001$; $df = 1$) than the hospital readmission rates. The hospital readmission rate has ranged between 56-63% over the period.

READMISSION RATE SUMMARY TABLE

Report Date	VFW Clinic	Gulfport Psychiatry Svc.
1980	6%	56%
1981	18%	59%
1982	21%	58%
1983	17%	61%
1984	28%	63%

An Outpatient Satisfaction Survey has been conducted each year. Results of these surveys consistently indicate a high degree of satisfaction with the program and with the travel team members. Veterans and their families have made many favorable comments about the program.

The Mobile VFW clinic program has been estimated to cost approximately $15,000 per year. The average cost per veteran is approximately $25.00 per visit. This is considerably lower than the daily hospitalization rate for inpatient treatment.

DISABLED AMERICAN VETERANS

DEPARTMENT OF ALABAMA

Senior Vice Commander
James H. Jackson

Congressman Shelby, Distinguished Guests, Fellow Veterans, Ladies and Gentlemen. It is indeed a pleasure for me to appear as a witness at this hearing. I am in total support of a VA Full Care Medical Center in the Mobile Alabama area. I am James H. Jackson, a Life member of the Air Force Sergeants Association, Veterans of Foreign Wars, and the Disabled American Veterans; a member of the American Legion and have served on the Mayors Advisory Council for the Handicap, City of Mobile. I am currently Senior Vice Commander Department of Alabama, Disabled American Veterans.

Upon my forced medical retirement from the United States Air Force in 1979 after 23½ years military service, I have worked with and for the handicapped, our veterans and their families with my limited funds as a retiree at my own expense. I represent 14,049 Disabled American Veteran Members in the State of Alabama and that is only approximately 20% of the Disabled Veterans in this great State. In the 4th District, which is from Luverne AL south to Florida and West to MS and East to GA there are 3300 DAV members, also in the 1st District of Florida, which is the Panhandle there are over 6000 members, this again is approx 25% of the Disabled Veteran population. In this area the Central Gulf Coast, including the Florida Panhandle, there are over 149,000 Veterans of which receive little to NO VA medical service or care. WHY? Because the usage of VA Medical Care facilities coorelates very closely to the availability of an adequate VA Medical Care Facility, which there are NONE in this area. A number of Veterans can not and do NOT use VA Medical Care Centers because they can not afford to take the time off from work for that day as it could mean their job or gas or food for the next week. This 149,000 does not include

thousands more that are retirees and Veterans that are working and using their own priviate Insurance and/or DOD Medical facilities.

Our Service Officers, Chapter Commanders and Officers are the life line for many Veterans, that of geting sick Veterans to and from the VA Medical Clinics and Hospitals. Making appointments, coordination between their local Dr's and VA facilities, going to their homes assisting the families, the list is a never ending one! Allow me just one example of the crowded condition of our nearest VA Medical Center, Biloxi MS: A 100% service connected Disabled Veteran, Mrs. Groth, of the Fairhope area was having problems breathing along with other medical conditions which her local Dr. advised her she should be admitted to a Hospital for immediate care. She went thru the normal procedures, our local clinic who did'nt see the need for hospitalization also there were no beds available at Biloxi MS, she called me for advice and I told her to have her Dr. call the local Clinic Dr. then the Biloxi MS admissions Dr and explain her condition, he did and to no avail. The following morning she felt as though her condition was worse so she called Mr. Harry N. Walters directly explained the situation. She reported to Biloxi, MS the following morning, as advised by Mr. Walters, and was greeted with open arms, stayed for three weeks. That was a 100% Service Connected Disabled Veteran. All others go on a waiting list and hope! I sincerely believe a full Care VA Hospital in Mobile AL would not significantly decrease the work load or reduce the Staff of any VA Medical Care facility up State or in any adjoining State as there are Veterans waiting for beds, and Veterans that need care that are just not getting it now.

We Veterans of the Central Gulf Coast and the Panhandle of Florida have a tremendous, immediate need! that of availability of an adequate VA Medical Care Facility. Current occupance at VA facilities nationwide have been over 80% and that has been with only an extimated 25% of the total veteran population using VA-operated medical facilities. A recent VA survey revealed that as many as 60% would use VA facilities if they knew they were eligible - - which they are. Although the total veteran population is anticipated

to decline by 15% by the year 2000, the veteran population along the Central Gulf Coast will increase by over 1% during the same period. Therefore, veterans growth along the Central Gulf Coast will be 16% greater than the nation as a whole. Estimates include an additional 7500 to 8000 veterans expected in the Medical District 10 service area due to the Tennessee-Tombigbee project. An Alabama Veterans' Affairs study of nursing home care for veterans, (Ernst & Whinney), ranked Mobile first as a potential VA nursing home/ domicilary site due to its location and its major veteran population. Presently, VA guidelines for assessing the need for veterans nursing home beds indicate that over 1000 beds are needed in Alabama. The two Alabama VA nursing homes are operating at 94% occupance, which means that for all practical purposes these facilities are full, furthermore, neither of these facilities are located in Southern Alabama. There already exists a real Veterans need for nursing home care, which is estimated will increase 100% by 1994.

The American Medical Association has urged Congress to require that the VA investigate the purchase of lease of existing under-utilized medical facilities before initiating any significant new or replacement construction of federal health care facilities. The VA Medical District 10 MEDIPP 1983 Plan and the "Florida Panhandle Workbook" both recommend renovations and new construction. The cost of current VA construction plans for 150 nursing home beds in South Alabama is approximate $8 million. The "Florida Panhandle Workbook" recommends the construction of a 225-bed VA Medical Care Center at Fort WAlton Beach, Florida at an estimated cost of approximately $67½ million based on the VA's current cost estimates of $300,000 per bed. Since no construction has begun, it can only be assumed that future construction will cost more, as construction scheduled for 1990's. We have an immediate need at present for a VA Hospital on the Central Gulf Coast not in the year 1990 or 2000. With the aging veteran and their projected needs we may stll need a VA Hospital in Florida by the year 1990 or 2000, then with the death rate being such as it is we may not.

There is an excellent Medical facility, by all inspectors standards, that will become vacant in a few months that could service the 100,000 plus veterans of the Central Gulf Coast and the Panhandle of Florida. Will also relieve the overloaded conditions and the excessive workload of the nearest VA Medical CAre Center in Biloxi, MS at a savings of almost $80 million tax dollars. Over 50% of the veterans on the Central Gulf Coast are located within one hour's driving time to Mobile, Alabama. Thus, locating a VA Medical Care Center in Mobile would lead to the highest likely usage by Veterans. It would have the support of hundreds of Dr.'s in the local area, including the fine University of South Alabama Medical Centers modern facility, Techonology, and their latest Scientific expertese. It also would create 1000 plus jobs for the City of Mobile, which would considerably help it's sagging economy. We urge you to take a positive step forward for the veterans and make this a Pilot project we all can be proud of. The bottom line is how can Congress or the Veterans Administration overlook this proposal in light of the increasing need to care for our veterans. Many of whom gave the ultimate sacrifice and thousnads more were mamed and scared for life with memories and wounds that will never be forgotten.

Thank You!

James H. Jackson
Senior Vice Commander
Phone: 205-343-3663

VETERANS HOSPITAL COMMITTEE

AMERICAN EX-PRISONERS OF WAR
James F. Drake

AMERICAN LEGION
John M. Tyson

DISABLED AMERICAN VETERANS
James H. Jackson

MARINE CORPS LEAGUE
William B. Jones

VETERANS OF FOREIGN WARS
Bob Bowerge

March 21, 1985

Congressman Richard C. Shelby
Committee on Veterans Affairs
Subcommittee on Hospitals & Health Care
355 Cannon House Office Building
Washington, D.C. 20515

Dear Congressman Shelby:

Please accept the sincere thanks of the Veterans Hospital Committee for your support of our Providence Project, and for arranging and conducting the Hearing in Mobile last week.

We believe your work will be instrumental in focusing attention on the plight of the Gulf Coast veteran and on the excellent solution to our problem the purchase of the Providence Complex would be. It is unfortunate that we have interference or opposition from some members of our own agency and our own bretheren, but there is so much good to this plan for so many people that it simply must be carried through.

During the Hearing you asked us to submit our comments in writing for the record, and we are pleased to do so. The enclosed Statement is respectfully submitted for the Hearing record, representing members of the American Legion, Veterans of Foreign Wars, Ex-Prisoners of War, Vietnam Veterans, Marine Corps League, and tens of thousands of veterans at large.

Again, our sincere thanks and appreciation for your work in behalf of the veterans of South Alabama.

Sincerely yours,

John M Tyson

John M. Tyson, Sr.

James H. Jackson, Sr.

VETERANS HOSPITAL COMMITTEE

AMERICAN EX-PRISONERS OF WAR
James F. Drake

AMERICAN LEGION
John M. Tyson

DISABLED AMERICAN VETERANS
James H. Jackson

MARINE CORPS LEAGUE
William B. Jones

VETERANS OF FOREIGN WARS
Bob Boserge

STATEMENT

SUBMITTED FOR THE RECORD

CONGRESSIONAL HEARING

COMMITTEE ON VETERANS AFFAIRS

UNITED STATES HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON HOSPITALS & HEALTH CARE

MOBILE, ALABAMA

MARCH 15, 1985

NEED FOR A VETERANS ADMINISTRATION FACILITY ON THE CENTRAL GULF COAST

NEED

As leaders of the major veterans organizations, we have, for many years, been acutely aware of the agony suffered by our members' inability to obtain desperately needed medical services. Some of the elements and evidence of need present in this situation do not seem to draw any attention from the V.A. We can hear at every veteran gathering about waiting lists, lack of availability of beds, long distances, and long waits. We are aware that this inability to obtain services is not unique to veterans living in southern Alabama, but is also a problem suffered by our distinguished members living in both Mississippi and Florida. One has only to look at the use rate of Veterans Administration medical facilities by veterans along the central Gulf Coast to come to the irrefutable conclusion that additional medical facilities are desperately needed. This use rate is 2% of that of eligible veterans, as compared to the national use rate of 20%. Having heard pleas from our members for assistance in obtaining needed medical services, we can assure you that having the lowest rate in the entire nation is not due to a lack of desire by our membership to use Veterans Administration medical facilities. Having the lowest rate in the nation is due to the undeniable fact that medical facilities along the Gulf Coast are totally inadequate to meet the critical needs of area veterans. Mileages and veterans locations are also critical and are, in fact, the only factor that the V.A. will admit to considering in planning. Mileage considerations are complex and confusing, because not every V.A. facility provides every category of care. The tertiary care to be provided in Mobile is now the least available to the Gulf Coast veterans and any veteran, in Mobile or elsewhere, must travel long distances for acute care. While recognizing that the V.A. cannot place a hospital near every veteran, we find it quite disappointing that the V.A., and particularly District Ten,

is reluctant to join us in our efforts. We are aware of their inside influences as to, "turf", and other political influences. We do not see our project as harmful to any other veteran anywhere. Historically, however, the agency has been only one member of the team that works in behalf of veterans. Aside from veterans themselves, the Congress has been at the forefront of providing veteran care as well evidenced by this hearing.

It appears that everyone is in agreement that additional medical facilities are desperately needed along the central Gulf Coast. The Florida Panhandle Study, developed by Medical District Ten, shows a minimum need for approximately 215 medical-surgical beds to serve the needs of the eight counties located in the Panhandle of Florida. Medical District Ten studies also show a need for 87 hospital beds to serve the needs of the veterans in Baldwin, Clark, Mobile, Monroe, and Washington Counties in southern Alabama. Using Medical District Ten's figures, one could conclude that there is a need for a minimum of 302 additional medical-surgical beds to serve the veteran population living in the five Alabama coast counties and eight Florida Panhandle counties. A recent study conducted by Pannell, Kerr & Forster stated that, "over 50% of the veterans on the central Gulf Coast are located within one hour's driving time of Mobile, Alabama." Approximately 70% of the veterans along the central Gulf Coast live within one and one-half (1½) hours' driving time of Providence Hospital. The study concluded that, "locating a Veterans Administration Medical Center in Mobile would lead to the highest likely usage by Gulf Coast area veterans."

In addition to the need for a minimum of 302 hospital beds, Medical District Ten also projects a need for an additional 1,050 nursing home beds in the State of Alabama. A recent study conducted by Ernst & Whinney, Inc. concluded that Mobile and southern Alabama was the Number One priority of additional nursing home facilities. The Alabama Department of Veterans Affairs and the State Veterans Home Committee are very favorable toward acquistion of the School

of Nursing building connected to Providence Hospital as a suitable veterans home. This could be easily done and would put the Alabama Veterans Home Committee years ahead of schedule in their goal to establish veterans' homes. Currently, there are none in south Alabama.

Even though everyone is in complete agreement that additional medical facilities are desperately required to meet the medical needs of the Gulf Coast veterans, there is considerable difference of opinion on where those facilities should be located. Without the availability of Providence Hospital in Mobile, one might conclude that additional facilities should be located in the exact geographical and population center of the Alabama and Florida counties. With the availability of Providence Hospital, however, it seems that logical men would address the practicality and the cost effectiveness of purchasing an existing facility located near a fully accredited medical university. Acquisition of Providence Hospital, located within one hour's driving time of over 50% of the veterans on the Gulf Coast, would not only provide the 302 hospital beds projected as needed by Medical District Ten, but would also provide facilities for the acute shortage of nursing home beds needed in southern Alabama. We pray that your committee, in this time of budget crisis, can set aside the debate on location and concentrate on the practicality and cost effectiveness of acquiring Providence Hospital to meet the pressing medical needs of all Gulf Coast veterans.

Unfortunately, many of our members, both in Alabama and Florida, would never live to benefit from a <u>newly</u> constructed facility in either location, since a newly constructed facility could not be complete and opened before 1995. We respectfully point out the necessity for additional medical facilities to meet the Gulf Coast veterans needs is <u>now</u> - <u>not 1995</u>.

MEDICAL SCHOOL AFFILIATION

Much has been written in the past several years on the advantages of locating Veterans Administration Medical Centers in close proximity to university medical schools. The University of South Alabama College of Medicine is located in Mobile, Alabama, in close proximity to the site of Providence Hospital. The University of South Alabama College of Medicine is the only medical school along the central Gulf Coast. The Medical College is a member of the Association of American Medical Colleges, and is accredited by the Liaison Committee on Medical Education.

The location of a Veterans Administration Medical Center at the Providence Hospital site would greatly benefit both the Veterans Administration and the University of South Alabama College of Medicine, according to Doctor Stanley E. Crawford, Dean of the College of Medicine. The benefits from such an arrangement are numerous, as follows: 1) An affiliation with the College of Medicine would permit the V.A. to recruit a more outstanding qualified medical staff than might otherwise be possible; 2) the V.A. would have the use of professional and administrative resources of the College as needed; 3) the two entities could share expensive equipment in order to avoid needless duplication, yet provide maximum use of the equipment for the V.A. patients; 4) the College of Medicine would be available to provide medical, nursing, and allied health staff with continuing medical education; and 5) the V.A. would have use of the quality consultant services of the faculty of the College of Medicine on a selected basis.

The location of a Veterans Administration Medical Center at Providence Hospital, in close proximity to the University of South Alabama, is in keeping with many well documented studies showing that the affiliation between the Veterans Administration and medical schools inevitably generates significant research and medical studies. Research funding greatly enhances

the effectiveness of both the medical school and the Veterans Administration hospitals. It would be sad, indeed, if the Veterans Administration did not take advantage of the opportunities available by not locating the proposed additional facilities needed by Medical District Ten near the only medical college located along the central Gulf Coast.

CONDITION OF PROVIDENCE HOSPITAL

As you could see from your subcommittee's tour of the hospital, Providence Hospital is in excellent condition. At the request of the Office of the Administrator, officials from the Veterans Administration Department of Medicine and Surgery, and the Office of Construction, conducted a facility survey of Providence Hospital on March 26-28, 1984. The purpose of this visit was to was to review the facilities of Providence Hospital, determine its condition, and consider its potential adaptability for use as a V.A. Medical Center.

The seven person survey team was headed by Mr. Robert L. Neary, Jr., Director of the V.A. Facilities Planning Service. During their two and one-half day intensive survey, this team examined Providence Hospital from basement to rooftop. They examined mechanical, electrical, plumbing, and support systems of the hospital, in addition to its architectural and structural condition. The team carefully examined the building for asbestos and found none.

In his report, Mr. Neary described the Providence Hospital complex as a 349 bed acute care hospital, containing modern coronary and intensive care units, a 34 station renal dialysis unit, modern support services, radiation therapy services, a 120 bed School of Nursing dormitory, and paved parking areas to accommodate 1,000 vehicles.

After analyzing the data collected during the survey, the V.A. team concluded that the Providence Hospital building is well maintained and in good to

excellent condition. The survey team report concludes: "IT IS THE TEAM'S BELIEF THAT IF A PROGRAMMATIC DETERMINATION WERE MADE TO ESTABLISH A VETERANS ADMINISTRATION MEDICAL CENTER IN MOBILE, THE PROVIDENCE HOSPITAL COULD BE ADAPTED TO SERVE THIS ROLE."

In addition to Mr. Neary's team site visit, Mr. Ralph Casteel, Special Consultant to the House of Representatives Veterans Affairs Committee and an authority on veterans facilities, visited Providence Hospital on April 2-3, 1984. At the conclusion of Mr. Casteel's visit to Providence Hospital, he reported the following observations to Chairman Montgomery:

1) The Providence Hospital in Mobile, Alabama is a well equipped and excellently maintained tertiary care hospital. 2) The appraised value of the property is $24 million. The appraisal was accomplished by the firm of Courtney & Morris Appraisals, Inc., of Mobile. This firm is a member of the American Institute of Real Estate Appraisers, and the Society of Real Estate Appraisers. The value would appear to be a very fair market price for this property. Mr. Casteel reported, "In my opinion, it (Providence Hospital) could be obtained at a most favorable price."

Mr. Anthony J. Principi, Counsel for the Senate Veterans Affairs Committee, visited Providence Hospital on July 18, 1984 and reported his findings to Senator Alan K. Simpson. Based on Mr. Principi's report, Senator Simpson concluded in a letter written to Harry Walters, Administrator of Veterans Affairs, that "Should the need for an additional V.A. Medical Center be determined through the MEDIPP for the Florida Panhandle and southern Alabama, I would request that consideration be given for the acquisition of an existing facility such as Providence Hospital."

In addition, hundreds of area veterans have also toured the entire facility during the past year. Everyone locally agrees with our distinguished visitors from Washington, D.C. that Providence Hospital is in excellent condition and could be readily adapted serve as a V.A. medical facility.

COST EFFECTIVENESS

The appraised value of Providence Hospital is $24 million. This appraisal was completed by the firm of Courtney & Morris Appraisals, Inc., of Mobile, Alabama. This firm is a member of the Institute of Real Estate Appraisers, and the Society of Real Estate Appraisers. The $24 million appraised price includes the 349 medical-surgical beds, a 126 bed School of Nursing dormitory building, and a connecting 300 seat auditorium. The Florida Panhandle Workbook, developed by Medical District Ten, recommends the construction of a 225 bed Veterans Administration Medical Center at Ft. Walton Beach, Florida, at an estimated cost of approximately $67,500,000.00 based on the V.A.'s current cost estimates of $300,000 per bed. In addition, the Alabama Veterans Affairs Nursing Home Study recommends the acquisition of or new construction of a 150 bed nursing home facility in southern Alabama at an approximate cost of $8 million. The total cost of constructing the 225 bed hospital as proposed by Medical District Ten and the 150 bed nursing home facility as proposed by the Alabama State Department of Veterans Affairs would be $75,000,000. Assuming construction costs will increase at a conservative 3% per year, the cost of a new facility in 1995 would be not less than $100 million.

In a recent study by Pannell, Kerr & Forster, comparing the acquisition cost of Providence Hospital to the construction cost of a new facility located in Ft. Walton Beach, Florida, the firm stated it favored acquistion of Providence Hospital by the Veterans Administration, based on the $24 million appraisal price which is a cost of approximately $69,000 per bed, savings to the V.A. of $231,000 per bed. In addition to this savings, the study indicated that Providence Hospital included a wing suitable for conversion to a nursing home that would result in an additional savings of approximately $8 million.

Mr. Ralph Casteel, Special Consultant for the House Veterans Affairs Committee, in his report to Chairman Montgomery, stated, "V.A.'s per bed cost estimate for construction would put new construction (Ft. Walton Beach) at an estimated $67.5 million for a new 225 bed facility." Mr. Casteel stated that this 349 bed facility (Providence Hospital), including necessary modifications, would cost much less.

In a February 2, 1984 report to the United States Senate on the Budget, Mr. David Stockman offered eight possible areas for future structural reform and major budget savings. Mr. Stockman reported that there are ways the nation can provide health care to its veterans at substantially lower costs. He stated that this, however, could come about only if current policy framework within the Veterans Administration is adjusted. Among the recommended structural reforms made by Mr. Stockman was the option of requiring the V.A. to make wider use of excess facilities in the private health care system. It appears to us that the purchase of Providence Hospital, deemed to be in excellent condition by a Veterans Administration Site Survey Team and Mr. Ralph Casteel, Special Consultant to the House Veterans Affairs Committee, would be in keeping with the recommendations made by Mr. Stockman. In addition to Mr. Stockman's report, the Veterans Administration document, "Caring for the Older Veteran", stated that in order to satisfy the projected needs and demands, the Veterans Administration must choose from several options - new construction, acquisition of existing capacity through purchase or lease, federal support of state facilities, and various contractual arrangements for services. The report clearly states the Veterans Administration is committed to meeting real health care by using the most cost effective options that provide for high quality health care.

The American Medical Association has also urged Congress to require that the V.A. investigate the purchase or lease of existing underutilized medical facilities before initiating any replacement construction of federal health care facilities. The cost effective acquisition of Providence Hospital is in keeping with the policy position of the Veterans Administration, the recommendations of the Office of Management and Budget, the recommendations of the American Medical Association, and the policies of the present Administration. In this period of budget deficits and fiscal crisis, it is inconceivable that the officials of Medical District Ten could not see the cost effectiveness of the acquisition of Providence Hospital over the development of a new, smaller facility located in Ft. Walton Beach, Florida, costing approximately four times as much as Providence Hospital.

SUMMARY

To summarize our position, we submit the following:

1) The veteran population along the central Gulf Coast will increase at a rate in excess of the national average. The heaviest concentration of veterans live in the Mobile area. The second largest concentration of veterans is in the Pensacola area, which is within commuting distance to Mobile. Over 50% of the veterans living along the central Gulf Coast are within one hour's driving time of Mobile.

2) The veteran population will continue to age, requiring a significant increase in V.A. medical services. The Alabama Veterans Affairs Study on Nursing Home Care for Veterans ranked Mobile first as a potential V.A. nursing home/domiciliary site due to its location and major veterans population.

3) Representatives of the major service organizations have voiced united support for the establishment of a V.A.M.C. in Mobile to meet the growing and currently unmet needs of the veterans along the Gulf Coast of Florida and

Alabama. Use rate by area veterans are the lowest in the nation due to the inaccessibility of current facilities. The Medical District Ten studies conclude that an additional 302 hospital beds are needed to meet the growing needs of veterans in southern Alabama and the Panhandle of Florida.

4) Additionally, the Alabama Department of Veterans Affairs projects a need for an additional 150 nursing home beds in Alabama.

5) Providence Hospital, a 349 bed acute care hospital, with an attached 126 bed School of Nursing, has become available and could be used to meet this identified need in a much more cost effective manner than building a new facility. The use of existing private facilities to meet V.A. needs is in keeping with the position of the Office of Management and Budget, the Veterans Administration, and the American Medical Association. Providence Hospital could be purchased by the Veterans Administration for one-fourth (1/4) of cost of constructing a new, smaller facility.

6) Providence Hospital has been determined to be in good to excellent condition and adaptable to serve as a V.A.M.C. by an engineering firm from the Veterans Administration Central Office.

7) The location of the University of South Alabama College of Medicine practically adjacent to the Providence Hospital greatly enhances the proper staffing of a V.A.M.C. The V.A.'s current policy prohibits the construction of a V.A. hospital where there is no medical school.

8) In an economic climate when the budget cuts and economy are the rule, a chance for the V.A. to save amost $70 million should not be overlooked.

9) A recent announcement by Congressman Hutto of a multimillion dollar comprehensive outpatient facility that is funded and under construction. This facility will alleviate the need for emergency and outpatient services for the Panhandle, while acute cases could be stabilized for transfer to Mobile.

10) Currently, the need for additional medical services for the veterans along the Gulf Coast if now - not 1995.

CONCLUSION

We unanimously agree with Mr. Ralph Casteel's observations and recommendations in his report to Chairman Montgomery. Mr. Casteel's observations were:

1) "The Providence Hospital, Mobile, Alabama, is a well equipped and excellently maintained tertiary care hospital.

2) The appraised value of the property (less medical equipment) is $24 million. The appraisal was accomplished by the firm of Courtney & Morris Appraisals, Inc., of Mobile. This firm is a member of the American Institute of Real Estate Appraisers, and the Society of Real Estate Appraisers. The value would appear to be a very fair market price for this property.

3) Most, if not all, of the medical equipment in the Providence Hospital could be purchased by a buyer through negotiations. This would include such items as a computer system, CAT Scanner, and sophisticated laboratory equipment. In my opinion, it could be obtained at a most favorable price.

4) It has been consistently emphasized by the Committee Staff that the need for a V.A. Medical Center in this area must be determined by the V.A. Should such a need by determined to exist in southern Alabama, or the Panhandle of Florida, it would be both prudent and economically essential for serious consideration to be given to acquiring this property. V.A.'s cost per bed estimate for construction would put new construction at an estimated $67.5 million for a 225 bed facility. This 349 bed facility, including necessary modifications, in my opinion, would cost much less.

5) The location of the University of South Alabama College of Medicine, practically adjacent to the Providence Hospital, greatly enhances the proper staffing of a V.A. Medical Center at this location, as opposed to the communities of Ft. Walton Beach, Panama City, and Pensacola, Florida.

6) The heaviest concentration of veterans in the area discussed is in Mobile County, Alabama. This is followed by the three most western counties of the

Florida Panhandle (Escambia, Santa Rosa, and Okaloosa), all of which are located within reasonable commuting distance of Mobile."

In light of the above, Mr. Casteel stated: "I believe this matter should be further pursued with the Administrator of Veterans Affairs, and my recommendations are that:

1) Should the V.A. determine that there is a need for a medical center to serve the veterans in the Panhandle of Florida and southern Alabama, the Administrator be urged to give serious consideration to the acquisition of Providence Hospital, Mobile, Alabama.

2) Should the V.A. determine that a new V.A. Medical Center is to be constructed in the Panhandle of Florida, as recommended by the Panhandle of Florida Workbook, the agency be required to show that Providence Hospital would not be suitable to meet the needs of veterans in south Alabama and the Panhandle of Florida, and it would not be economically feasible to purchase this property versus new construction. This can be accomplished under the authorization process required by Section 5004, Chapter 81, Title 38, U.S.C.

3) Should the V.A. opt for new construction in either of the three locations mentioned in the Florida Panhandle Workbook (Ft. Walton Beach, Panama City, and Pensacola), the agency be required to show that staffing of such facility can be accomplished without undue difficulty and that the quality of care to be provided would be comparable to or exceed that which is provided in the community of Mobile, with a close affiliation with the University of South Alabama College of Medicine."

We urge your Committee and the Veterans Administration to seriously consider the approval to purchase Providence Hospital as a demonstration project to test the cost effectiveness and feasibility of using alternatives to provide for the increasing veterans needs in times of budget crisis. The Office of

Management and Budget, the Veterans Administration, the American Medical Association, and several highly respected consultants have all suggested that the development of such alternatives may well be the only approach to meet the needs of an aging population.

In the case of Providence Hospital, the need for an additional facility has already been established by the Medical District Ten planning process. The facility has been deemed to be in good to excellent condition by a team of engineers from the Veterans Administration. It is located in close proximity to an accredited medical college, and is far more cost effective than constructing a new facility. The Veterans Administration will never find a better opportunity to test the feasibility of utilizing alternatives to the high cost of medical care provided by the Veterans Administration.

KILBORN & GIBNEY
ATTORNEYS AT LAW
1806 DAUPHIN STREET
MOBILE, ALABAMA 36633

P. O. Box 1904
TELEPHONE (205) 450-1881

March 19, 1985

Congressman Alan B. Mollohan
516 Cannon House Office Building
Washington, D.C. 20515

Congressman Wayne Dowdy
214 Cannon House Office Building
Washington, D.C. 20515

Congressman Richard Shelby
1408 Longworth House Office Building
Washington, D.C. 20515

Re: Providence Hospital

Gentlemen:

Please accept this as a follow-up letter to the hearing by the special sub-committee chaired by Chairman Richard Shelby in Mobile, March 15, 1985. You may add this letter to the hearing record in support of John Tyson's testimony.

It was certainly nice to meet all of you in Mobile and I am sorry that your visit was so short. Hopefully you can again come to Mobile to partake of some of our Mobile hospitality.

I find it necessary to rebut some of the statements made by the Florida delegation who seem to emphasize that there was a large Veterans population in the Panhandle of Florida if the sub-committee considered twelve counties in the Panhandle of Florida. I wish to point out that there are not twelve counties in the Florida Panhandle which are in District 10. There are only eight. In the Preliminary MEDIPP Report prepared by Hugh Vickerstaff, Medical Director of District 10, on page 12, you will notice that in all four Scenarios outlined by the Preliminary Report, the eastern most county in the Panhandle of Florida shown in the four MEDIPP Scenarios is Okaloosa County where Fort Walton is located. Only three Florida Counties are considered by the Veterans Administration to be pertinent to a Mobile Veterans Administration Medical Center, to-wit, Escambia, Santa Rosa, and Okaloosa. It is apparent that the Florida delegation counted population in counties that are not even under consideration. This is irregardless of whether one considers the three counties mentioned by the MEDIPP Report or all eight Florida counties in District 10.

The four MEDIPP Scenarios which discuss population figures only compare seven counties in Alabama, to-wit, Baldwin, Clarke, Conecuh, Escambia, Mobile, Monroe and Washington, and three counties in Florida, to-wit, Escambia, Okaloosa and Santa Rosa. On page 12 of the Preliminary Report, a copy of which I enclose, you will notice that by 1990 the Veterans

population in the three Florida counties plus the seven Alabama counties is 133,017 Veterans. You will notice that even if we subtract Santa Rosa and Okaloosa Counties in Florida the suggested Alabama-Panhandle PSA would still be projected to have a Veteran population by 1990 of 104,276 Veterans. This more than meets the VA's own 100,000 minimum population for a 200 bed hospital. Thus, the major cities in the area being Pensacola, Florida and Mobile, Alabama and their surrounding areas would more than meet the population need for a VA Hospital.

Contrary to Donald Thompson's testimony, population projections made by responsible organizations show a steady growth for the Mobile area. Bureau of the Census data shows the population of the seven county area of Mobile, Baldwin, Washington, Escambia, Monroe, Clarke and Conecuh Counties in Alabama to be 491,095 in 1970, increasing to 565,034 in 1980. Projections prepared by the Mobile District Office of the U.S. Army Corps of Engineers shows the population of this area increased to 589,939 in 1984 with projected increases to 595,006 by 1985, 623,697 by 1990, 644,698 by 1995 and 664,483 by the year 2000. I have no idea where the Veterans Administration gets the idea our population will decrease.

It is very probable that these growth projections will in reality be even higher due to the increasing discoveries of oil and gas in our area.

Another comment which must be rebutted is the testimony by Donald Thompson who stated that it was not a VA criteria that a VA Hospital be associated with a medical school. Mr. Thompson is playing on words since in the July 1984 publication by the Veterans Administration "Caring For The Older Veteran", which is Harry Walter's Bible, it is stated at page 11-4 under "General Criteria For Construction Priorities", under Criteria #6 that, "Availability of the health care manpower needed to operate the facility" is a mandatory criteria. This obviously means either a medical school or something very close to it. As I understand what Florida testified to, the only sources of staffing for a VA Hospital in the Panhandle would be that, (1) one of the witnesses testified that he had heard from some nurses that they would like a VA Hospital located in Fort Walton, and (2) that there is supposed to be an over abundance of physicians in the future and that some of these physicians, they would ask you to assume, would be located in the Panhandle.

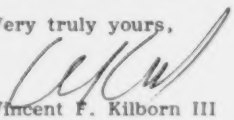
As you know, if the Veterans Administration is going to provide health care to Veterans, the care should be high quality care. High quality care can definitely be rendered by the physicians produced by the University of South Alabama Medical School. If the Veterans Administration built a new hospital in the Panhandle there would only be a "hope" that staffing would magically appear out of the blue. What a horrible mistake it would be to build a brand new hospital with weak prospects for staffing. Harry Welters noted in a recent article, a copy of which I enclose, that "VA is on the cutting edge in the field of aging research and geriatric care. How we provide care for older Veterans will help shape a national system for

providing care to all of the aged in America." It is obvious to me and I think to you, that in order for the VA to stay on the "cutting edge" of anything, it must be closely associated with a school of medicine. Cutting edge research and health care is not going to be delivered by any other institution.

As Alan Mollohan pointed out the ideal situation would be if Providence were located in the Panhandle. However, it is not. The need and the availability of the facility is now, not 1995. No one knows what will happen by 1995. I strongly urge you and the committee to seize this unique opportunity.

If there are any points which Florida has raised which you would like some more information on, I will be happy to provide you with the facts. Again, I enjoyed very much meeting with you and hope that you will be in our area again so that we can demonstrate southern hospitality.

Very truly yours,



Vincent F. Kilborn III

VFK:pjm

Enclosures

PROVIDENCE HOSPITAL
MOBILE, ALABAMA

In early 1984, the Deputy Administrator was contacted by Sen Jeremiah Denton with a proposal that the VA purchase Providence Hospital in Mobile, Alabama, and establish a VA Medical Center. Providence is owned by the Sisters of Charity. It is in urban Mobile and a new Providence is being built in the suburb.

In March a team from DM&S and Office of Construction visited Providence at the request of the Deputy Administrator. The buildings were found to be attractive and in good shape.

Since there had been no identified need for an inpatient medical facility in Mobile, Medical District 10 was charged with evaluating the present veteran population in the area which might be served by Mobile; the projected population by the year 2,000; the VA services already available; impact on these services if an inpatient facility were to be established, and impact on already planned services such as the Outpatient Clinic at Pensacola.

The above analysis was done and a decision made by the District Planning Board, the District Executive Council, the District Director and the Regional Director that there is not an identified need for the establishment of a VA Medical Center in Mobile. The decision was made based on the following:

1. The largest veteran population not being served presently is in the Florida Panhandle.

2. The establishment of an inpatient facility in Mobile would impact on:

   a. VAMC Biloxi - a 20% impact on workload and resources
   b. VAMC Montgomery - 5%

3. There is an already established Outpatient Clinic in Mobile serving the veterans in that area and the Biloxi VAMC is 54 miles from Mobile.

4. There is a $100 million dollar project in process for the renovation and upgrading of Biloxi VAMC.

The decision that the VA does not need to establish an inpatient facility in Mobile was concurred with by the Acting Chief Medical Director.

The recommendation to inform Providence that the VA does not intend to establish a facility in Mobile, therefore, will not pursue any available facilities (there is also an HCA facility for sale) nor construction has been forwarded to the Administrator for final approval.

This has been an extremely politically sensitive issue. The veterans group in Mobile has obtained considerable political support, the Florida Panhandle veterans have strong political support for a planned VA facility there (MEDIPP and 30-year Florida Study) and there has been political interest in assuring no loss of resources to Biloxi VAMC.

HELEN C. COBBS
Health System Specialist
Southeastern Region (10BA3)

RESOLUTION

WHEREAS, The American Legion has endeavored over the past several years, working with the Veterans of Foreign Wars, the D.A.V., and other Legion posts to establish a Veterans Administration hospital in Mobile in conjunction with the University of South Alabama, Medical Center, and

WHEREAS, the veteran population, present and projected, is more in the surrounding areas and would justify in all respects the establishment of a Veterans hospital in this city, and

WHEREAS, the Veterans Administration is aware that new facilities must be established to meet the increased needs of the many veterans from WWI, WWII, Korea and Vietnam, as well as those who are in the armed forces, and

WHEREAS, recently the Providence Hospital of Mobile has made plans to relocate in the western section, thereby making their up-to-date complete hospital and nursing facility available to the Veterans Administration within a matter of months, and

WHEREAS, this Providence facility is a modern and complete hospital complex and is located in the near vicinity to the University of South Alabama Medical Center and other major hospitals of the Mobile area, and

WHEREAS, the University of South Alabama Medical School has pledged their complete cooperation in the acquisition of the Veterans Administration hospital to be located at Providence.

NOW, THEREFORE, BE IT RESOLVED

1. That The American Legion does hereby endorse and recommend that the Veterans Administration of the United States Government shall locate a Veterans Administration hospital at Providence Hospital on Springhill Avenue at Catherine Street, Mobile, Alabama, and

2. That all individuals and groups of this area actively participate and work towards that end, and

3. That proper committees composed of citizens from all segments of Mobile society be formed as a task force for the completion of this project, and

4. That the members of our congressional delegation, both House and Senate, be immediately notified and encouraged to support this noble effort, and

5. That communication be held immediately with local posts of the American Legion, the Veterans of Foreign Wars, Disabled American Veterans and other interested groups to encourage them to adopt similar resolutions and work for the establishment of this Veterans Administration center, and

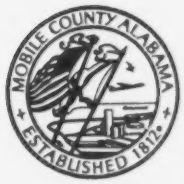
6. That a copy of this resolution be forwarded to The American Legion, Department of Alabama, for presentation to the Department Convention and that appropriate copies be forwarded to the congressional delegation and other interested parties, including the National Convention in Salt Lake City, Utah.

CERTIFIED TRUE COPY OF RESOLUTION APPROVED AT STATE CONVENTION JULY 28, 1984.

Melvin Hudson

Melvin Hudson, Department Adjutant
The American Legion, Department of Alabama

JAMES L. "JIM" MASON, PRESIDENT
OLIVETH M. ARCHER, COMMISSIONER
DOUGLAS WICKS, COMMISSIONER



W. C. HELVESTON
ADMINISTRATOR
DOUGLAS L. MOOLING
DEPUTY ADMINISTRATOR

MOBILE COUNTY COMMISSION
POST OFFICE BOX 1443 MOBILE, ALABAMA 36633

March 14, 1985

The Honorable Richard Shelby
The United States House of Representatives
Member, Subcommittee on Hospitals and
Health Care
Room 1705
Longworth House Office Building
Washington, D. C. 20515

Dear Mr. Shelby:

I wish to thank you for the opportunity to enter my support for the location of a veterans' hospital in Mobile, Alabama into the official record of this hearing. Attached is a Resolution of the Mobile County Commission urging location of a facility in Mobile to provide services for the numerous veterans residing in the metropolitan area.

The closest veterans' hospitals are located in Biloxi, Mississippi to the west, Montgomery to the north and Jacksonville, Florida to the east, comprising an area of approximately 34,657 square miles. Consequently, there is a tremendous need for a veterans hospital inside of this area and Mobile, with Providence Hospital available, is the most logical site. Additionally another facility would make the others more effective by reducing the doctor/patient ratio and providing easier accessibility for the veterans.

Once all factors are considered it becomes obvious that Mobile is the best site for a veterans' hospital due to the number of veterans served, the geographical location in relation to existing facilities and more efficient services resulting from a lower doctor/patient ratio. Mobile County stands ready to aid you in your efforts to locate a veterans' hospital here.

If I may be of further assistance please feel free to call me at (205) 690-8615.

Sincerely,

James L. Mason
President

DAN WILEY, PRESIDENT
WILLIAM E. HAYS, COMMISSIONER
DOUGLAS WICKS, COMMISSIONER

W. C. HELLESTON
ADMINISTRATOR
DOUGLAS L. MODLING
DEPUTY ADMINISTRATOR

MOBILE COUNTY COMMISSION

POST OFFICE BOX 1443 MOBILE, ALABAMA 36633

RESOLUTION

WHEREAS: It is the desire of the Mobile County Commission to honor and provide assistance to veterans of the American armed services whenever possible and to promote the interests of the courageous men and women who served their country so unselfishly; and

WHEREAS: The many veterans in Mobile County and the adjacent areas are without hospitalization facilities in the immediate area; and the number of veterans, currently and in the future, justifies the establishment of a veterans' hospital in Mobile; and

WHEREAS: Providence Hospital has made plans to relocate in the western section of the city, thereby making available to the Veterans Administration a complete, modern facility encompassing both a hospital and nursing facility ready for occupancy in the immediate future; and

WHEREAS: Providence Hospital is located near other hospitals, and the University of South Alabama Medical Center has pledged support and cooperation in this endeavor;

NOW, THEREFORE, BE IT RESOLVED: The Mobile County

Commission strongly urges the Veterans Administration to consider locating a hospital in the Providence facility to provide health care to the numerous veterans in our area.

ADOPTED this third day of February, 1984.

MOBILE COUNTY COMMISSION

Dan Wiley, President

William E. Hays, Commissioner

Douglas Wicks, Commissioner

Attest:

W. C. Helveston
Administrator

RICHARD SHELBY
7TH DISTRICT, ALABAMA

COMMITTEES
ENERGY AND COMMERCE
SUBCOMMITTEES
FOSSIL AND SYNTHETIC FUELS
HEALTH AND THE ENVIRONMENT
U.S. TRADE WITH CHINA
VETERANS' AFFAIRS
SUBCOMMITTEES
COMPENSATION, PENSION, AND INSURANCE
CHAIRMAN
HOUSING AND MEMORIAL AFFAIRS

Action

WASHINGTON OFFICE
ROOM 1705
LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, D.C. 20515
(202) 225-3885

DISTRICT OFFICES
FEDERAL BUILDING
TUSCALOOSA, ALABAMA 35401
(205) 752-3578
COURT HOUSE
BESSEMER, ALABAMA 35020
(205) 428-6031
FEDERAL BUILDING
SELMA, ALABAMA 36701
(205) 872-2884

Congress of the United States

House of Representatives

Washington, D.C. 20515

March 4, 1985

Commissioner James Mason
County of Mobile
Post Office Box 1443
Mobile, Alabama 36633

Dear Commissioner Mason:

The House Committee on Veterans' Affairs, Subcommittee on Hospitals and Health Care, will conduct a hearing in Mobile, Alabama, beginning at 10:00 a.m. CST, Friday, March 15, 1985, in Courtroom #3, U.S. Courthouse, 113 St. Joseph Street, Mobile, Alabama, 36602. I will chair this subcommittee hearing, the purpose of which will be to take testimony regarding the location of a VA Medical Center in the south Alabama-western panhandle of Florida area.

As you know there has been an intense interest in having the VA acquire the Providence Hospital to serve veterans in the south Alabama-western panhandle of Florida area. You are invited to appear as a witness at this hearing and present your views on this subject. Written testimony will be taken for the record, but it would be appreciated if your oral testimony could be limited to seven minutes or less.

If you have any questions regarding this hearing, please contact Anne Caldwell of the Committee staff at (205) 225-2665.

Sincerely,

Richard Shelby

Richard Shelby
Member,
Subcommittee on Hospitals and Health Care

VETERANS HOSPITAL COMMITTEE

AMERICAN EX-PRISONERS OF WAR
James F. Drake

AMERICAN LEGION
John M. Tyson

DISABLED AMERICAN VETERANS
James H. Jackson

MARINE CORPS LEAGUE
William B. Jones

VETERANS OF FOREIGN WARS
Bob Bosarge

VETERANS HOSPITAL PROJECT

PROVIDENCE HOSPITAL
MOBILE, ALABAMA

BRIEFING DATA

UPDATED TO 01 MARCH 1985

PROVIDENCE HOSPITAL
MOBILE, ALABAMA

--VETERANS HOSPITAL PROJECT UPDATE
OCTOBER 25, 1984

Much has happened since the January beginning of the effort to have the Providence Hospital complex converted to a Veterans Medical Center. A tremendous effort has developed, with significant contributions being made by our civic and political leaders, Commanders and members of the Veterans' organizations, and many other friends of veterans in South Alabama. The effort has already taken in hundreds of people and organizations, and continues to grow and grow.

We have spent most of our time working on our local project but it would be helpful to note some of the problems the VA faces nationally. Don't forget that the care of the veteran by the Veterans Administration is absolutely required by law and the VA will be spending ten to fifteen billion dollars more per year by the year 2000.

Currently only 20% of the eligible veterans over 55 use the VA. In our case, where VA facilities and services are very difficult to use, the use rate drops to one tenth of the national average. Essentially, our veterans do not have VA services available! The veterans say nationally that 60% of them would use the VA if they were eligible and VA services were available.

The VA is now operating 80,000 beds. The Veterans Administration says it will need an additional 134,000 beds by the year 2000 because of huge increases in the number of elderly veterans. This is a 68% increase! In fact, the VA must have an increase of over 16,000 beds in the next five (5) years!

In 1980 only 10.5% of the 28.6 million veterans were over 65. By the year 2000 over 39% of veterans (over 7,000,000) will be over 65. Even by 1990 one of every two men 65 or older will be VA eligible. All veterans over 65 are VA eligible...and, American men over 65 have more than twice the number of hospital stays per capita than men 45 to 64. These same dramatic increases also apply to veterans under long term care. In 1984 there are 15,000 veterans under long term VA care. By the year 2000 that number will actually multiply to 760,000.

The upshot of all this is that actual veteran need for VA services for which they are eligible could double in the next fifteen years. We can safely assume that this intensification of need will intensify on the Gulf Coast as well as elsewhere in the United States, all of which enhances the veterans Hospital Committee Case.

As a matter of fact, in a climate of substantial and increasing need, the Veterans Administration has the opportunity to acquire a large, modern VA facility complete with substantial advantages on the Gulf Coast for less than one thousandth of the national annual VA budget, and then operate it annually for less than one thousandth. Since the VA has only 172 medical centers costing an annual $26 billion, this would seem to be a cost analyst's dream.

This information all sets the climate in which we are seeking to bring the VA to Providence Hospital in Mobile.

This update will outline the most significant events and report results, and outline the items that have emerged as the most significant factors in South Alabama's "Case" for a VAMC in Mobile.

The Providence complex has been visited by individuals or teams from several governmental agencies:

1. The VA Facilities team, headed by Mr. Robert Neary, Director of Facilities Planning Services, examined the hospital for three days and reported that the Providence complex could feasibly be converted to a VAMC.

2. An adjunctive report to that of Mr. Neary was made by Doctor Murray Mitts, Director, VA Program Analysis and Development, Department of Medicine and Surgery. Although less positive than the facilities report, it did outline a clear and growing need for a VAMC on the Gulf Coast.

3. Mr. Donald Layfield, Regional Administrator for the General Services Administration, and the "landlord" for many VA facilities, visited Providence and found it highly suitable for a VAMC.

4. Mr. Ralph Casteel, a consultant for the House Veterans Affairs Committee, visited Providence has issued a very positive report to the House Veterans Affairs Committee. This report is a summary of the project and is the most favorable document produced anywhere so far.

5. Several members of the staff of the Alabama Department of Veterans Affairs have visited Providence, and as a matter of fact, the Alabama Department of Veterans Affairs, under Mr. Frank Wilkes, has become a very strong advocate of the conversion of the Providence complex to a VAMC.

6. Delegations from Mobile regarding Providence have also traveled to Birmingham to see Mr. Hugh Vickerstaff, Region Ten VA Director; to Montgomery to see Mr. Frank Wilkes; and to Washington to visit the VA Headquarters and our legislators in Washington.

7. On June 28, 1984, Mayor Lambert Mims led a delegation to Washington from the City, all three City Commissioners, both Alabama Senators, President of the Mobile Chamber of Commerce, Commanders of the VFW, DAV and American Legion, Alabama Director of Veterans Affairs, Congressmen Edwards, Shelby and Montgomery all met with the City delegation. The delegation then met with officials of the Veterans Administration.

8. On July 18, 1984, representatives of both the Senate Veterans Affairs Committee and the Veterans Administration visited the Providence complex. Mr. Anthony J. Principi, Chief Counsel of the Senate Committee, Allen Cameron from Senator Denton's office, Richard Falco,

Deputy Director, Facilities Planning, Engineering and Construction, and J. L. Warnock, Assistant Medical Director for VA Region 10 composed the visiting team. Response was very favorable, including a statement by Mr. Warnock that "There is a certified need for a new VAMC along the Gulf Coast and that need is growing." Feedback from that meeting is very favorable and visits to the complex are now being planned by Appropriations Committee personnel from Washington.

9. On July 27, 1984, Providence was visited by Mr. Hugh Vickerstaff, Director of VA Region 10 and Mr. Frank Wilkes, Director, Alabama Department of Veterans Affairs, State of Alabama. The Department of Veterans Affairs is an avid supporter of the VA project and is also interested in the Nursing School as a possible Veterans Home.

10. On August 2, 1984, the actual MEDIPP process in District 10 met with the Community Advisory group in Tuscaloosa. The proposal will be made to place acquisition of the Providence Hospital complex as a serious recommendation. Although VA Headquarters in Washington, as well as legislative personnel, have made a serious study of the Providence Hospital complex, local planning and recommendations are an important functional part of the process.

11. On September 13, 1984, the District 10 Executive Council, composed of the Directors of all the facilities, met in Birmingham as a part of the District 10 Planning Process.

12. On October 25, 1984, Senator Howell Heflin met with hospital and veteran officials, toured the hospital and then attended a reception with over 100 veterans where he expressed not only suppport, but his intention to actively work toward project success.

13. On October 28, 1984, Vice President George Bush visited Mobile, was briefed on the project, and was very supportive.

14. On October 29, 1984, Senator Stennis visited Mobile and was briefed on the project by Senator Heflin and his staff.

15. On October 30, 1984, an independent feasibility study, done by the national firm of Pannell-Kerr-Forster was released. In summary, this analysis clearly outlines veteran health care needs on the Gulf Coast and is very supportive of the Providence Hospital project. Copies of this report have been distributed to key advisors to the project in Mobile and in Washington.

16. Early in November, 1984, District 10 submitted to the VA Central Office its planning document for 1984. Surprisingly, the VA took very little note of the Providence Hospital project, absolutely ignored much of the material and testimony assembled by the project, and, persisted in a long range plan for a hospital in the Florida Panhandle.

As a result of Senator Denton's efforts, these planning documents were rejected by VA Central Office; and, VA Administrator, Harry Walters,

notified Senator Denton that the matter was open and all people involved would be contacted and all information would be re-evaluated and a new decision reached.

17. On February 28, 1985, Mr. Hugh Vickerstaff and Bill King, Planner from District 10 in Birmingham, and Mobile veteran leaders met for a complete review of the Providence Hospital project. Transcripts of those proceedings were then carried to Washington to assure that all available information was in the hands of the VA Central Office.

Although long-range VA plans to place a VAMC in the Panhandle certainly recognizes veteran need, the fact is that even with positive growth, the veteran population in the Panhandle will never justify new construction. Mobile, Alabama is the nearest location to west Florida veterans, where all the requirements for a VAMC come together.

As a result of all these visits and the planning and staff work resulting, the actual rationale and "Case" for the conversion of the Providence complex to a VAMC, has grown stronger and stronger. Most readers of this update will already be familiar with the blue book "Case".

The Providence Hospital complex is a highly suitable location for a VAMC for several very important reasons:

Veterans: Nearly 60,000 in Mobile and the two adjacent counties. Last year more veterans were treated by the VA from these three counties than from the entire Florida panhandle. These numbers continue to grow.

Costs: Providence is being offered at a cost of $69,000 per bed. VA current costs per bed in new construction range from $260,000 to $300,000 per bed, not counting land. In the current fiscal climate, an opportunity to greatly enhance VA services, which are mandated by law, and save $70 million in the process should be attractive, not only to the VA, but to Congress.

Veteran Support: Extraordinary, as is support from all segments of the community.

Community Impact: The economic impact of a VAMC on the community is difficult to forecast because the final number of employees, and final facility arrangements have not been determined. At any predicted level, however, they are very significant: Possible numbers of new jobs, for example, ranges from a low of 885 to 1,745. Possible annual payroll ranges from $20,144,547 to $38,110,800, and total community economic impact from a low of $141,011,829 to $266,775,600. These are just hospital figures alone, and do not consider outside business and relative visits with the veterans.

The Medical School: The University and Medical School are in solid support of the project and all experts list the Medical School as a major plus factor in locating a VAMC in Mobile.

The Veterans Administration does not routinely purchase facilities from other organizations, preferring to build their own. Because of the remarkable disparity between VA building costs and current facility prices, the

VA has been urged by the AMA and directed by Congress to consider purchasing where possible. The Providence complex represents a possible pilot purchase program in which the VA has expressed interest.

VETERANS HOSPITAL PROJECT UPDATE
OCTOBER 25, 1984

ANALYSIS OF VETERAN SERVICES

IN DISCUSSION - GULF COAST AREA

STATE	COUNTY	VETERANS	SERVICES	%
ALABAMA:	Mobile	42,990	1,058	4.1%
	Washington	1,580	65	.4%
	Baldwin	10,340	210	.2%
	Clarke	2,470	83	.3%
	Monroe	2,100	82	.4%
	Escambia	4,040	178	.4%
FLORIDA:	Escambia	34,740	440	.1%
	Santa Rosa	8,280	84	.1%
	Ocalcosa	16,910	153	.1%
	Walton	3,370	67	.2%
	Holmes	1,760	78	.2%
	Jackson	4,660	118	.2%
	Washington	1,820	85	.5%
	Bay	14,190	184	.1%
		149,240	2,885	1.9%

As a matter of information, the VA service level to veterans in our zone of District Ten is very low. Fourteen (14) Alabama and Florida Counties have 149,240 veterans (based on information from 1981), less than 2% of which use the VA at all. If our veterans used the VA at the national rate, the services total would have been 29,139, or more than ten times the actual rate. VA assessment of need based on usage is wrong. Usage is based more on availability than need, and the above picture is indicative that VA services in our area are not available.

In addition to the definite need for a VAMC in Mobile and the certified suitability of the Providence complex, there are many other factors which enhance this proposal. Not in years has a project come along which has enjoyed such total community support. No effort should be spared to bring this one to reality!

NOTE: For anyone interested in further information, detailed studies and comprehensive data is available by contacting Mr. Jack R. Lynch, or Captain Hal Pierce at Providence Hospital, 1504 Springhill Avenue, Mobile, Alabama 36604, (205) 438-7660.

STATEMENT BY

CONGRESSMAN EARL HUTTO

BEFORE THE

SUBCOMMITTEE ON HOSPITAL AND HEALTH CARE

COMMITTEE ON VETERANS AFFAIRS

U. S. HOUSE OF REPRESENTATIVES

MOBILE, ALABAMA

MARCH 15, 1985

Mr. Chairman, thank you for permitting me to come before your Subcommittee today. Having been raised in South Alabama and as a veteran of World War II, I am keenly aware of the needs of veterans living in Florida and Alabama. Also, as a life member of the Veterans of Foreign Wars and a member of the American Legion, I have the veterans' needs at heart and want to do all I can to help to provide an adequate medical facility for all concerned.

I stand in strong opposition to the purchase of Providence Hospital for three primary reasons. First, Providence Hospital is not the proper facility to suit the recommendations of the Medical District Initiated Planning Process (MEDIPP) study. The $69,000 per-bed cost of utilizing Providence Hospital is very deceptive. It is simply a division of the number of licensed beds by the overall $24 million to purchase the hospital. The $69,000 figure does not include equipment costs or the extensive renovation which would have to be done before the hospital could be used. Secondly, the VA has said that there is no need for a medical facility in Mobile because it is only 63 miles to the Biloxi

facility. Our Florida veterans must drive three to four hours to reach either Montgomery, Biloxi, or Gainsville. Furthermore, the Biloxi hospital is having $80 million worth of construction and renovation performed right now. This is money that has been appropriated and will be spent to improve the facility. To spend these tens of millions of dollars and then immediately abandon the purpose for spending these tax dolars is most unwise. Third and finally, there will be substantially more veterans in Northwest Florida in 15 years than there will be in South Alabama. This fact is the most compelling evidence to support the location of a hospital in Florida because the problem will not go away or diminish. Whether we act responsibly and address this problem now or later, it will have to be solved sometime in the near future. Clearly, the Veterans Administration has demonstrated that Northwest Florida has the greatest need for a VA Hospital and Census information confirms the Veterans Administration's data.

I ask the members of this Subcommittee, why should the veterans be satisfied with a cast-off hospital? Is the VA in the business of bailing-out hospitals? The men and women who will utilize the hospital have served their country proudly. The freedoms that we enjoy today were ensured by their valor, and we have the obligation to live up to our responsiblity to provide decent and adequate medical care. Getting a so-called bargain is not a valid reason to make a decision that will affect veterans for the next 20 years. There are no new data or credible information to suggest a change of the conclusion that the VA reached in the MEDIPP study. Surely, now more than ever, we are conscious of spending federal money. Spending $24 million on a facility that does not meet our needs is, simply, a waste. As a Conservative, I cannot stand idly by and allow the purchase of this white elephant. Let

us not pretend that veterans' interests will be met should the Providence Hospital be approved. I suggest that we focus our attention on helping those people that our decision will affect: the veterans.

Without a doubt, Florida has much to offer retiring veterans. Our beautiful beaches and temperate climate draw veterans from all parts of the country for their retirement and they are severely disappointed when they discover that there is not a VA hospital near-by. The population shift toward the Panhandle is not limited to veterans. Florida is growing at an alarming rate of over 6,600 new people per week and this trend is expected to continue well into the next century. We currently have four higher education institutions offering degrees in the health fields, and the presence of a VA hospital would be a mutually beneficial arrangement for both students and hospital staff. Finally, the military installations of Eglin & Tyndall Air Force Bases, the Naval Air Station at Pensacola, and the other branches of the Armed Forces in the 1st District of Florida have a personnel force of over 32,000 people. We have found that many of these people greatly enjoy their tour of duty in Florida and return at a later time to live.

Before closing, I would like to remind all of the members of the committee that the Veterans Administration is a reputable agency. They have a highly qualified staff who use the MEDIPP form of evaluation to guide an overall plan of serving veteran's needs. I respect the fine work that the VA does for our country and urge all of you to match their level of commitment to the veterans by locating a hospital in Florida.

Thank you for allowing me to testify before your Subcommittee today. I am grateful to all the veterans who fought in our nation's wars and I am dedicated to seeing that a new VA hospital be the best facility that it can be.

Earl Hutto

Member of Congress

Florida

AMVETS

AMVETS Post 78
858 John Sims Pkwy
Niceville, Florida 32578
678-9801

March 13, 1985

Honorable Representative Earl Hutto
330 Cannon Building
Washington, D.C. 20515

Dear Sir:

As the Commander of AMVETS (American veterans of World War II, Korea and Vietnam) I speak for 604 veterans who are members of Post 78 in Niceville, Florida. We are all alarmed at the information we are reading in our local newspaper pertaining to construction of a V.A. Hospital. I want to assure you that this membership wants a hospital here in Northwest Florida. We have never made a statement that we would be satisfied if one was built in Mobile, Alabama.

Senator Denton must pack some mighty clout, to be able to re-address an inadequate out-dated building that will require much more funds than has been stated to renovate and bring it up to standards required for patient care. I feel they must look at funds being spent now trying to update the VA Hospital at Montgomery, Alabama and when they are finished it will still be outdated for a lot of patient care. We need a modern facility and a closer one for the many veterans in Northwest Florida and we are one of the fastest growing areas.

Veterans from this area must travel to several different locations for different medical problems. I believe the same will be true if they renovate the old Providence Hospital in Mobile rather than building a new modern facility. In closing I would like to say that we are 100 per cent behind you and hoping that foresight is a constant figure in the deliberations on this project and that the end result is not just a repair job that will satisfy only a few.

SINCERELY, In AMVETS

Bill D. Bertran

BILL D. BERTRAN
Commander, AMVETS Post 78

Wainwright Post 2185
Veterans of Foreign Wars
of The United States
2136 N. Sherman Avenue
Panama City, Fl. 32405

11 March 1985

Sanford E. Sidebottom, Commander
AMVETS Deptartment of Florida
210 Edrehi Drive
Niceville, Fl. 32578

Dear Commander Sidebottom:

Commander Bishop, AMVETS Post 549, has asked for VFW Post 2185, to support you in your endeavors. Commander Sidebottom, you have our support in this matter.

VFW Post 2185, has been against a hospital in Mobil from the start. The need for a hospital here in the Panhandle is in great need with the Veterans population that we have here and growing.

With a post of 600 members I do know of the hardships placed on our Veterans getting to a VA Hospital from here and one in Mobil will not help us one bit in relieving this great hardship.

With the treatment that our Veterans are getting at this time in the Alabama VA Hospital is very bad as they could care less about Panhandle Veterans so why another could care Va Hospital in Alabama.

Commander Bishop, who is also my Jr. Vice Commander, has been handling many cases of complaints by the Veterans in the VA Hospital in Alambama has kept me posted on the progress of these complaints. Let Us keep our Flordia Veterans here in the state of Flordia. Let us respect our Veterans and stop this great and needless hardships.

Yours in Comradeship

Ralph McClendon

Ralph McClendon, Commander
VFW Post 2185
(904) 265-5753

AMVETS

AMVETS Post 78
858 John Sims Pkwy
Niceville, Florida 32578
678-9801

Richard Spiker, Commander
AMVETS, District IV of Florida
P.O. Box 316
Niceville, Florida 32578

March 14, 1985

The Honorable Representative Earl Hutto
330 Cannon Building
Washington, D.C. 20515

Dear Sir;

I am District IV Commander of AMVETS, (American Veterans of World War II, Korea and Vietnam) which covers all of the Florida Panhandle. I wish to convey my fellow veterans feelings regarding the location of a VA Hospital in Mobile, Alabama.

This location would be of little value to us, due to the distance required to travel from the major populated areas of the Panhandle, with the possible exception of Pensacola.

With the greatest concentration of veterans in the areas of Fort Walton Beach East to Apalachicola, it is our recommendation that this facility be located as central as possible in the Panhandle, favoring easy access to a major highway, such as Interstate 10.

Your favorable consideration and support of our position would be most appreciated.

SINCERELY,

Richard Spiker

RICHARD SPIKER
District IV Commander
AMVETS, Dept. of Florida

James W. Bishop, Commander
AMVETS Post 549
2036 Orlando Road
Panama City, Fl. 32405

11 March 1985

Sanford E. Sidebottom, Commander
AMVETS Deptartment of Florida
210 Edrehi Drive
Niceville, Fl. 32578

Dear Commander Sidebottom:

Commander, in request for support for a VA Hospital in the Panhandle, AMVETS Post 549, Panama City, We proudly pledge our support from the Post by each and every member. Commander not only Post 549 but letters from these other Veterans Groups are given to support you.

Why, why, a VA Hospital in Mobil, Alabama, when they are only 60 miles from the very fine Hospital at Biloxi, Mississippi. The Veteran population in Mobil is nile as compared to that of the Panhandle.

The need for patient services for our Veterans grows as the Veteran population grows in our community. Approximately 15,000 Veterans live in this area, while the nearest VA Hospital is 210 miles away.

The typical Veteran that is in need of medical services is either elderly and unable to withstand the rigors of such a trip or is young, unemployed and with a family to support and unable to pay for the transportation to the VA Hospital.

Whenever the Veteran is in the need for more than one visit for medical treatment and attention, the problem becomes very compounded.

Our County VA Office sees about 50 Veterans aday and the amount is increasing each month. There are many more Veteran that are taken care of by the Service Officers of the Veterans Groups as AMVETS, VFW, DAV and American Legion. County VA Office has no funds to get these Veterans to a VA Hospital. Service Officers of Veterans Groups do use Funds they have to help some of these Veterans and the Service Officers themselves are using thier own funds to take these Veterans to VA Hospital. On top of this they are giving of thier time to take these Veterans to VA Hospital in thier own automobiles. We Commanders and Service Officers break prior appointments to help our fellow Veterans often causing us great hardship and loss of income.

Our feelings, that is us Veterans in the Panhandle feel that

VA has neglected and ignored the Veterans of the Panhandle long enough. Veterans of the Panhandle will not have thier problems and hardships relieved by placing a VA Hospitel in the Mobil area. It does appear that VA doesnot give a DAM about nearly 28,000 Veterans in the Panhandle area. These men and women answered the call of thier country and now they are being ignored and put into postion that greatly degrades them and stripping them of thier pride.

Yours in AMVETS

James W. Bishop, Commander
AMVETS Post 549
2036 Orlando Road
Panama City, Fl. 32405
(904) 785-3188

AMERICAN LEGION
W. C. COOPER, SR. POST 66
POST OFFICE BOX 58
PANAMA CITY, FLORIDA 32402

11 March 1985

Sanford E. Sidebottom, Commander
AMVETS Deptartment of Florida
210 Earehi Drive
Niceville, Fl. 32578

Dear Commander Sidebottom:

Commander Bishop, AMVETS Post 549, discussed with me on 12 Maech 1985, your request for support, I, Ken Brown, as Commander of American Legion Post 66, do give you one hundred per cent support on this matter.

Post 66, has been against a VA Hospital in Mobil from the start. This will not relieve the hardship of our Veterans here in the Panhandle. Many of our members are in the older age group.

The number of Veterans in South Alabama, Mississippi and Louisiana is on a steady decrease and greatly increaseing in the Panhandle. Therefore, the VA Hospital at Biloxi would only be half of it's capability. So , why have to VA Hospitals only 60 miles apart while the plight and hardship of the Panhandle Veteran still has not yet been addressed.

With budget cuts in Veterans programs is it not the time that VA woke up and stop listening to these selfish and very inconsiderate politicians of Alabama.

The Panhandle Veteran needs help and some relief from the hardships put on them the distance they have to travel to a VA Hospital for medical treatment. We answered our countrys call now, PLEASE, VA answer our call.

Yours in Comradeship
Kenneth L Brown
Ken Brown, Commander
American Legion Post 66
(904) 763-1072

AMVETS
American Veterans of World War II, Korea and Vietnam
DEPARTMENT OF FLORIDA
210 EDREHI DRIVE • NICEVILLE, FLORIDA 32578
Sanford E. (Sam) Sidebottom
COMMANDER
TELEPHONE 1-904-678-7967

March 5, 1985

The Honorable Harry N. Walters
Administrator of Veterans Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Mr. Walters:

On behalf of the American Veterans of World War II, Korea and Vietnam, (AMVETS), Department of Florida, I wish to inquire about the Veterans Administration's position in the controversy over the Providence Hospital in Mobile versus building a new VA hospital in Northwest Florida.

Some important answers are needed to clarify statements of the VA District 10 Director, Mr. Hugh Vickerstaff made in Mobile, Alabama on Thursday, February 28, 1985 as quoted in the Ft. Walton Beach, FL Playground Daily News of March 2, 1985. Quote: "Vickerstaff said he went to Mobile on an information-gathering mission. He said he was told by VA Headquarters to get information on the need for a VA hospital in Mobile, and described a decision on that need as "totally and completely seperate from anything in the Panhandle." Unquote.

If the Veterans Administration adheres to the wishes of Senator Jeremiah Denton of Alabama under the pretense of considering the savings of buying Providence hospital, what have we saved?

It will cost millions of us taxpayers dollars to renovate this facility to meet VA standards. If this was such a fine hospital, how come they built another one?

Mr. Walters, let's not allow the David Stockman Doctrine (taking away from the veteran to save money) influence the reaching of this most important decision.

As you know, veterans living in the Panhandle, or NW Florida are truly hurting for a VA Medical Center. These veterans must now travel many miles to receive medical treatment and/or hospitalization to Mongomery, (150-200), Birmingham, (233-283), Tuskegee, (185-235), or Biloxi, MS., (200-250). The nearest VA Medical Center to us in NW Florida is the Lake City VA Medical Center, a distance of 292 miles from Pensacola, FL.

The above facts are illustrated to show that if the VA gives in to Senator Denton's wishes, you and I know that NW Florida's veterans will be required to use the Mobile Medical Center. Our veterans oppose this due to traveling more than 70 miles to reach a VA Medical Center, (100 miles plus to Mobile), Mobile's high crime rate, possible hurricane evacuations, traffic congestion and corruption in general.

It has also been brought to my attention that a delegation from Alabama is visiting veterans organizations in Florida urging them to build a VA hospital in Alabama. They are well organized and their literature is misleading in that they state that all veterans organizations in NW Florida agree with their plan. Nothing is further from the truth.

The AMVETS and all other veteran organizations in NW Florida ask for your fullest consideration for a new VA Medical Center in the Florida Panhandle. This area's concentration of veterans from Pensacola to Panama City is evidence of the attractiveness of what retired people are looking for and since so many of them served here, it is only natural to return to a good place to live. Many thousands more will retire here within the next 5 to 10 years. Therefore, a VA Medical Center should have top priority.

Thanking you in advance for your support.

SINCERELY,

Sam Sidebottom

Sam Sidebottom
State Commander,
AMVETS, Dept. of Florida

Copies to:
Congressman Earl Hutto
Senator Paula Hawkins
Senator Lawton Chiles
AMVETS National Commander,
John Lorec

Department of Administration

BOB GRAHAM
Governor
GILDA H. LAMBERT
Secretary of Administration

DIVISION OF VETERAN AFFAIRS
POST OFFICE BOX 1437
ST. PETERSBURG, FLORIDA 33731
(813) 896-4443

SIMON F. STOVER
Director

STATEMENT OF SIMON F. STOVER, DIRECTOR
FLORIDA DIVISION OF VETERANS AFFAIRS
BEFORE THE SUBCOMMITTEE
ON HOSPITAL AND HEALTH CARE
OF THE COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES
MOBILE, ALABAMA
MARCH 15, 1985

Mr. Chairman and Members of the Subcommittee:

It is an honor and a great pleasure for me to have the opportunity today to appear before you.

The 1.4 million veterans of Florida and the State of Florida support the VA Medical District 10 plan for hospital construction in the Medical District.

I will discuss five areas of concern.

1. The Medical District Initiated Program Planning (MEDIPP) process must be utilized.

This grass roots planning program is based on the premise that local knowledge of demand, resource needs and existing capabilities will result in more efficient services and better resource utilization than decisions based on planning which is solely centrally directed. The Medical District 10 plan states that a hospital should be built in the Florida panhandle. A hospital in Mobile is not included in the plan. To circumvent this system at this time would set a dangerous precedent and effectively throw sound planning procedures out the window throughout the entire VA health care system.

2. The Mobile hospital would not greatly effect health care availability for veterans residing in the Florida panhandle.

At the present time over 70,000 veterans living in the Florida panhandle are outside a 100 mile radius of existing VA facilities. If the Mobile hospital were in place today this number would decrease to 45,000. However, by the year 1990 this number climbs to 60,000+ and continues to grow. In effect, having a hospital in Mobile does very little to alleviate an existing problem.

Therefore, regardless of the supposed savings in purchasing an existing plant, this facility would actually cost more since it will not meet the needs of the veterans.

3. Drawdown on Biloxi/Gulfport VAMC.

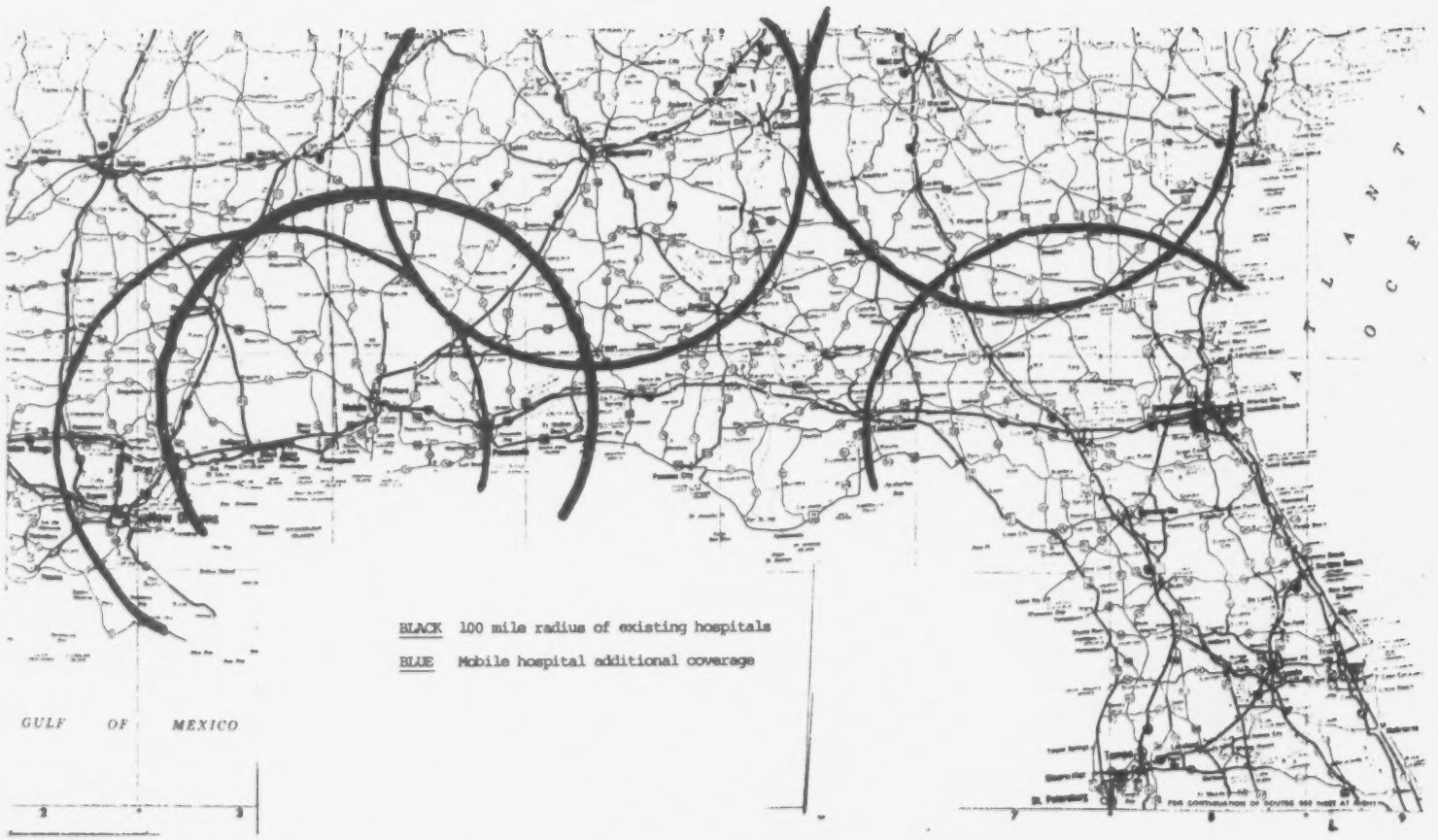
The Veterans Administration is completing a total upgrading of the Biloxi VA hospital at a cost of $80 million. The placement of a hospital in Mobile would have a 66% (of the 146,200 veterans in Biloxi PSA, 98,650 live in Alabama and Florida) drawdown affect on the Biloxi hospital effectively making it a nursing home and long term psychiatry facility. This would be a significant waste of taxpayers' money.

4. VA bed ratio per 1,000 veterans.

At the present time the national average bed ratio is three beds per 1,000 veterans. Alabama enjoys a four beds per 1,000 veteran ratio while Florida has a two beds per 1,000 veteran ratio. If a VA hospital is located in Mobile, Alabama's bed ratio increases to 4.38 beds per 1,000 veterans and Florida's ratio remains at two beds per 1,000 veterans.

5. Veteran immigration.

More veterans are moving to Florida than to any other state in the nation. The numbers are particularly significant when comparing Alabama to Florida. During the years 1975 through 1980, 6,776 veterans moved to Alabama and 135,998 veterans moved to Florida. This means that for every veteran that moved to Alabama, 20 moved to Florida. Of more importance is the immigration of older veterans (60 years old and older). This group of veterans requires significantly more health care than other groups. From 1975 to 1980, Alabama gained less than 2,321 veterans age 60 and over, while Florida gained 73,492. The future is even more significant. VA projections indicate that Florida will continue to outgrow the nation.


BLACK 100 mile radius of existing hospitals
BLUE Mobile hospital additional coverage
GULF OF MEXICO
ATLANTIC

Bay County Veterans Service Office

224 East 3rd Court
Panama City, Florida 32401

March 14, 1985

Mr Sanford Sidebottom
Commander, AMVETS, Department of Florida
210 Edrehi Drive
Niceville, FL 32578

Dear Mr Sidebottom:

At the request of Jim Bishop, I wish to offer the following information on the needs of veterans in Bay County, Florida.

As is well known by all of us in the Panhandle, the lack of medical care for veterans rank at the top. Rarely does a day pass that I don't have an ill veteran in this office who often needs immediate medical attention, most often he is accompanied by his wife or other family member for he is too weak to come alone. It is my unpleasant task to inform the veteran that is 200 miles to the nearest Veterans Administration Medical facility, and even if he is capable of gotng that distance, there is no way I can assure him (or her), just how long he may have to wait for an appointment to see a doctor.

For the older veteran, their physical condition hinders travel of that distance, and his income is not sufficient to pay his way if he were able to travel. On the other side of the coin, the younger veterans are hampered from travel for reasons of not enough income to defray the expense since he usually has a family to support from poor paying jobs, and of course, he loses the time and pay while off the job, and often he even loses his job.

I have an average of 50 people in this office each day, a large part of these people require medical care, but are unable to obtain care for the reasons stated above, and the situation grows worse each day. There are an estimated 15,000 veterans in Bay County and the number is growing. Yes, I can fully say based on the needs of Bay County alone, coupled with the other counties in the Panhandle, a medical facility is justly warranted and needed in this area. There is an estamated 100,000 veterans in the Panhandle area, the majority of which does now, and will in the future require medical care.

It is my firmest hope that through the vast interest generated amoung all veteran organizations, representative of the state and other parties that by some stoke of fortune we will be provided with a medical facility that at least is within reach of this area.

Please rest assured that I, as the Veterans Service Officer in this county will do my utmost to promote and encourage the Veterans Administration Medical Facility in this area.

Sincerely

IVY Barrow
Veterans Service Officer

NICEVILLE
VALPARAISO
BAY AREA

Chamber of Commerce

170 JOHN SIMS PARKWAY
VALPARAISO, FL 32580
(904) 678-2323

March 14, 1985

Veterans Administration
810 Vermont Ave.
Washington, D.C. 20420

Dear Sirs:

We here in the Niceville-Valparaiso Bay Area, attest a strong interest in a hospital for the veterans of our ward who live throughout our area, and further request that it be located in Northwest Florida.

During my 23 years in the military, I have personal knowledge of the need for an additional hospital for these veterans. At present the distance traveled for hospitilization is a constant problem and a growing threat to the health of these individuals.

In the past the number of veterans in our area were at a point where a hospital of this kind was not feasible. This is no longer the situation. The number of veterans has grown by astronomical proportion. It is now apparent that there is no justification for a delay of construction of another V.A. facility and that it should be located in the Northwest Florida area where the greatest growth of the veteran population exists. Your humane consideration is requested that a new veterans hospital be built in Northwest Florida. I respectfully request your immediate attention to this problem.

Respectfully,

Jack Dempsey
President

JD/k

Robert L. F. Sikes
CRESTVIEW, FLORIDA
32536

March 13, 1985

Veterans Administration
810 Vermont Avenue
Washington DC 20420

Gentlemen:

This letter attests to my strong interest and support for a new hospital for America's veterans of our wars and for it to be located in the area known as Northwest Florida.

During my thirty-eight years as a Member of the United States Congress from Florida, I had firsthand information again and again of the need for additional hospital facilities for veterans. Distances which had to be traveled for hospitalization were a constant problem and a growing threat to the health of this important group.

During those years, the number of veterans was held to be insufficient to justify another hospital. This is no longer the case. The number of eligible veterans has grown by leaps and bounds. It is now an accepted fact that there is no justification for further delays in the construction of another facility. Nor should there be any serious question about the location. Northwest Florida is centrally located and is the area of greatest growth in veteran population.

Humane considerations require that a decision be reached without further delay to locate a new veterans' hospital and that Northwest Florida be designated. I respectfully urge that this be done.

With every good wish, I am

Sincerely,

BOB SIKES
Member of Congress (Ret.)

S/lw

Please reply to: 805 U.S. 90 East, Crestview FL 32536

ESTABLISHED 1958

NORTHWEST FLORIDA
RETIRED OFFICERS CLUB, INC.

ARMY • NAVY • AIR FORCE • MARINE CORPS
COAST GUARD • COAST AND GEODETIC SURVEY
• PUBLIC HEALTH SERVICE •

P.O. BOX 310
FORT WALTON BEACH, FLORIDA
32549-0310

March 12, 1985

The Honorable Earl Hutto
Room 203 Federal Building
P.O. Box 187
Panama City, Florida 32401

Dear Mr. Hutto:

Members of the Northwest Florida Retired Officers Club, Inc. have expressed overwhelming support for the establishment of a new Veterans Administration Hospital in the northwest Florida area.

Our club has nearly 900 members in the Greater Fort Walton Beach and surrounding Okaloosa County area, (including Crestview, DeFuniak Springs, Destin, Sandestin, Santa Rosa Beach, and Navarre Beach).

A Veterans Hospital in our area is urgently needed, and the placement of such a facility in Mobile, Alabama simply will not provide the medical support required for the many, many thousands of Veterans in our area.

We urge you to fiercely fight to have this new Veterans Hospital located in the geographical area of northwest Florida.

Sincerely,

Frank W. Mann, Jr.
Col USAF Retired
President

HOUSE SUBCOMMITTEE ON HOSPITAL AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
COURT ROOM #3, U.S. COURTHOUSE
113 ST. JOSEPH STREET
MOBILE, ALABAMA
MARCH 15, 1985 AT 10:00 A.M.

CONGRESSMAN SHELBY -- MEMBERS OF THE HEARING PANEL.

I AM DAVID W. CARTER. I HAVE BEEN EXECUTIVE DIRECTOR OF THE NORTHWEST FLORIDA AND BIG BEND HEALTH COUNCILS FOR THE LAST TWO YEARS. PRIOR TO THAT, I WAS THE EXECUTIVE DIRECTOR OF THE AREAWIDE HEALTH PLANNING AGENCY IN MONTGOMERY, ALABAMA FOR FOURTEEN (14) YEARS. I AM A GRADUATE OF AUBURN UNIVERSITY AND THE UNIVERSITY OF ALABAMA HEALTH SERVICE ADMINISTRATION PROGRAM. I HAVE ALSO PARTICIPATED IN REGULAR MEETINGS OF THE V.A. DISTRICT 10, MEDIPP COMMUNITY ADVISORY GROUP.

THE PURPOSE OF MY STATEMENT IS TO STRONGLY SUPPORT THE 1983 AND 1984 MEDICAL DISTRICT 10 PLAN FOR A V.A. HOSPITAL IN THE FLORIDA PANHANDLE. THE PLANNING PROCESS INCLUDING THE HARD DATA, THE PERCEIVED NEEDS OF THE VETERAN COMMUNITY AND THE TECHNICAL EXPERTISE OF PROFESSIONALS WERE ALL GIVEN EXHAUSTIVE EVALUATION IN THE DEVELOPMENT OF THIS PLAN. IN MY OPINION, IT IS ONE OF THE BEST JOBS OF PLANNING I HAVE WITNESSED IN MY SIXTEEN (16) YEARS AS DIRECTOR OF AN AREAWIDE PLANNING AGENCY.

ACCORDING TO THE <u>DATA BOOK</u> OF V.A. MEDICAL DISTRICT 10 AND THE V.A. OFFICE OF INFORMATION MANAGEMENT AND STATISTICS THE THREE COUNTIES OF SOUTHWEST ALABAMA, INCLUDING MOBILE, ARE PROJECTED TO DECREASE IN THE VETERANS POPULATION BY FIVE (5) PERCENT IN THE NEXT FIFTEEN (15) YEARS. THE VETERANS POPULATION IN THE SEVEN (7) SOUTHERN MISSISSIPPI COUNTIES AROUND BILOXI IS PROJECTED TO DECREASE 6.8%. ON THE OTHER HAND, THE VETERANS POPULATION IN THE TWELVE (12) COUNTIES OF THE FLORIDA PANHANDLE WEST OF THE APALACHICOLA RIVER IS PROJECTED TO INCREASE BY 18% DURING THAT SAME PERIOD.

ACTUAL PROJECTIONS BASED ON THE 1980 CENSUS ARE AS FOLLOWS:

SOUTH ALABAMA 1982	- 55,000 VETERANS
BY THE YEAR 2000	- 53,000 VETERANS
SOUTH MISSISSIPPI 1982	- 47,000 VETERANS
BY THE YEAR 2000	- 44,000 VETERANS
FLORIDA PANHANDLE 1982	- 93,000 VETERANS
BY THE YEAR 2000	- 110,000 VETERANS

YOU MAY ASK WHY THERE IS A PROJECTED DECREASE OF VETERANS FOR SOUTH ALABAMA AND MISSISSIPPI WHEN THE POPULATION IS SLOWLY INCREASING? THE ANSWER IS SIMPLE. FROM A DEMOGRAPHIC STANDPOINT THE GREATEST DEATH RATE AMONG MALES AGE 65 AND OLDER WILL BE IN THE LARGE SURGE OF WORLD WAR II VETERANS AND, THEREFORE, A SLOW INCREASE IN THE GENERAL POPULATION AS IS PROJECTED WITH THE TENNESSEE/TOMBUGBEE WATERWAY DEVELOPMENT WILL BE OFFSET BY THE HIGHER DEATH RATE OF OLDER MALE VETERANS.

THE OVERALL POPULATION PROJECTIONS FOR THE FLORIDA PANHANDLE INDICATE A SIGNIFICANT GROWTH FOR THAT AREA WHICH WILL OVERRIDE THE HIGHER DEATH RATE FOR WORLD WAR II AGE MALE VETERANS. IF YOU HAVE TRIED TO DRIVE ALONG THE PANHANDLE COASTLINE RECENTLY AS WE DID THIS MORNING, YOU KNOW THE POPULATION EXPLOSION THAT IS TAKING PLACE THERE. THESE ARE THE PROJECTIONS MY OFFICE DEALS WITH ON A DAILY BASIS AND IT IS EASY TO VERIFY THEIR ACCURACY BOTH ON A PROFESSIONAL AND PERSONAL BASIS.

A V.A. HOSPITAL PLACED IN MOBILE, JUST 60 MILES FROM BILOXI, WOULD LEAVE ONLY 44,000 VETERANS TO BE SERVED BY THAT FACILITY THUS DEVASTATING THE EXCELLENT PROGRAM DEVELOPED THERE THROUGH THE YEARS WHICH IS CURRENTLY EXPERIENCING AN $80 MILLION EXPANSION AND RENOVATION.

A V.A. HOSPITAL IN THE FLORIDA PANHANDLE WOULD SERVE APPROXIMATELY 110,000. THIS WOULD ALLOW THE APPROXIMATELY 100,000 VETERANS IN SOUTH ALABAMA AND MISSISSIPPI TO BE SERVED BY THE NEWLY REFURBISHED BILOXI FACILITY.

I HAVE HEARD SOME SAY THAT THE V.A. WILL BUILD ONLY TERTIARY AND AFFILIATED HOSPITALS, BUT THAT SIMPLY IS NOT SO SINCE THE FACILITIES RECENTLY APPROVED IN PALM BEACH AND BREVARD COUNTIES ARE PRIMARY/SECONDARY HOSPITALS.

IT HAS BEEN SAID THAT PANHANDLE VETERANS COULD BE BETTER SERVED BY A HOSPITAL IN MOBILE. I AM HERE TO TELL YOU IT IS 175 MILES FROM MY FRONT DOOR TO THE HOSPITAL IN MONTGOMERY, ALABAMA. IT IS 181 MILES FROM MY FRONT DOOR TO PROVIDENCE HOSPITAL IN MOBILE, ALABAMA. THAT KIND OF BETTER SERVICE WE DON'T NEED FOR THE VETERANS IN THE PANHANDLE.

IT HAS BEEN SAID THAT THERE ARE INSUFFICIENT NURSES AND PHYSICIANS IN THE FLORIDA PANHANDLE TO STAFF A V.A. HOSPITAL. BUT, I CAN CERTIFY TO THE FACT THAT THERE IS A SERIOUS SURPLUS OF NURSES IN THE PANHANDLE TODAY AND WE HAVE BEEN CONTACTED BY A NUMBER OF NURSES STATING THEIR INTEREST IN WORKING IN A V.A. HOSPITAL. THE THREE MILITARY HOSPITALS IN THE PANHANDLE PROVIDE EXCELLENT RECRUITMENT POTENTIAL FOR A V.A. HOSPITAL MEDICAL STAFF. FOR YEARS WE HAVE HEARD THAT BY 1990 THERE WILL BE A SURPLUS OF PHYSICIANS NATIONWIDE AND WE ARE ALREADY SEEING A GREAT DEAL OF COMPETITION FOR PATIENTS AMONG THEM. IT IS MY UNDERSTANDING THAT THE V.A. IS LOOKING AT THE NEEDS IN THE 1990S AND BEYOND, NOT THE UNMET NEEDS OF YESTERDAY.

THANK YOU VERY MUCH FOR THIS OPPORTUNITY TO SPEAK BEFORE YOU HERE TODAY. IF YOU HAVE ANY QUESTIONS I WILL BE GLAD TO ANSWER THEM IF I CAN.

ANTHONY J. PRINCIPI, CHIEF COUNSEL/STAFF DIRECTOR
JONATHAN B. STEINBERG, MINORITY CHIEF COUNSEL/
STAFF DIRECTOR

United States Senate

COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

August 27, 1984

Honorable Harry N. Walters
Administrator of Veterans' Affairs
Washington, D. C. 20420

Dear Harry:

I am writing about Providence Hospital, which is located in Mobile, Alabama. The Committee has been advised that Providence Hospital is for sale and that great interest has been expressed at the local, state, and national levels in the possibility of converting it to a Veterans' Administration Medical Center to serve the large and growing population of veterans in southern Alabama and the Florida panhandle.

Representatives of the major service organizations have told the Committee of their very strong support for the establishment of a VAMC in Mobile to meet the growing needs of veterans in that area.

Providence hopsital is an acute medical and surgical facility with 349 acute care beds, a 34 station renal dialysis unit, modern coronary and intensive care units and a nursing school dormitory with 120 beds. A large staff residence is located on the grounds. The buildings are on a 15.3 acre tract with 1,000 paved parking spaces.

During the past six months, a series of site visits have been conducted by officials from the Veterans' Administration and by the staffs of both the House and Senate Veterans' Affairs Committee. All the reports have concluded that Providence is a well equipped and excellently maintained tertiary care hospital with strong potential for rapid conversion to a VAMC. Moreover, its location in Mobile suggests benefits for staffing and for affiliation with the School of Medicine at the University of South Alabama.

Harry, you have often stated that we face enormous challenges in the months and years ahead if we are to meet the growing needs of our aging veterans population. That challenge is clearly spelled out in your recent report to the Congress. The demographics of the aging veterans indicate that there will continue to be significant growth in the Southeastern portion of the United States.

In my view, at a time when the national government faces many difficult choices among various competing and legitimate demands upon its resources, it is essential that we look at new, creative, and cost-effective techniques to meet the challenge. I know that you share that belief, for it has been reflected in your leadership of the VA.

I would like to request that your planning process at the Medical District and Central Office level carefully consider the possibility (including the cost effectiveness) of acquiring certain suitable facilities when appropriate rather than relying on the costly and lengthy approach of constructing new ones.

I fully recognize and appreciate that the need for and location of any additional VA Medical Centers must first be determined through MEDIPP. Should such a need be reaffirmed for the Florida panhandle and southern Alabama, I would request that consideration be given to the acquisition of an existing facility such as Providence Hospital.

Thank you for your consideration.

With warm regards,

Sincerely,

Alan K. Simpson
Chairman

AKS/ajp

PAULA HAWKINS
FLORIDA

United States Senate

WASHINGTON, D.C. 20510

March 14, 1985

The Honorable
Richard C. Shelby
Chairman, Subcommittee on
Housing and Memorial Affairs
House Veterans Affairs Committee
Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Shelby:

The veterans in the Florida Panhandle have an urgent need for a VA medical center within a reasonable driving distance of the veteran population centers.

I would appreciate your accepting the enclosed statement for inclusion in the record of the Subcommittee on Hospitals and Health Care hearings you are to chair at Mobile, Alabama on March 15, 1985.

Thank you for your attention to this matter. With my warm regards, I remain

Sincerely,

Paula Hawkins

Paula Hawkins
United States Senator

PH:jr

I firmly support the need for a new VA medical center in the Florida Panhandle. I strongly oppose the establishment of a VA hospital in Mobile, Alabama. The Veterans Administration has identified the Panhandle as a potential site for a new hospital as a part of its Medical District Initiated Program Planning (MEDIPP). The local effort to encourage the VA to acquire a hospital which has not been economically viable would cast doubt on the construction of a new VA hospital in the Panhandle where it is most needed.

The MEDIPP process is based on the premise that local knowledge of demand, resource needs and existing capabilities will result in more efficient services and better resource utilization than decisions based on planning which is only centrally directed. The MEDIPP is comprehensive and professional. I endorse the process and the findings.

The need for a hospital in the Florida Panhandle should be obvious. The Panhandle veterans population in Medical District 10 exceeded 83,000 (11.2% of the District total) in 1980 and is projected to exceed 101,000 (14.2%) in the year 2000. Most of the veterans are and will continue to be concentrated in three Panhandle counties; Bay, Escambia and Okaloosa Counties.

The more than 16,000 veterans residing in Okaloosa County presently must travel more than 120 miles one way for treatment at the VA Medical Center at Montgomery, Alabama, the nearest VA facility. The nearly 14,000 veterans residing in Bay County must travel more than 150 miles to Montgomery or to the VA Medical Centers at Gainesville and Lake City. A centrally located hospital in the Panhandle would bring the majority of Florida's veterans in that area within 75 miles of a health care facility.

The proposal for the Veterans Administration to acquire Providence Hospital in Mobile would serve the present ownership of the hospital and a relatively small number of veterans in the immediate Mobile area, but it would do nothing for the majority of veterans in the Florida Panhandle. Most Panhandle veterans are no closer to Mobile than they are to Montgomery, Tuskegee, Alabama, or Lake City and would thus not be served at all by the acquisition of Providence Hospital. The hospital, which is within 65 miles of Biloxi, would impact negatively on the Biloxi Medical Center--a facility programmed to receive $80,000,000 in new construction in the next five years.

The proposal to acquire Providence Hospital defies logic. Though Providence could admittedly be acquired for less than the cost of a new facility in the Panhandle--the saving is not as great as

some would have us believe--it is false economy for the future. It must be noted that while the Panhandle is projected to experience sustained growth in the foreseeable future. The Biloxi and Montgomery PSA's are projected to experience a decrease in veterans population if the eight Florida counties are subtracted. With the exception of the Florida counties that would be included, the veterans population in a Mobile PSA would surely also decrease in the coming years. Savings in construction cost would be eaten up by travel costs.

As costly as it is to construct new hospitals, construction costs pale when measured against operational costs. A few years of operational costs exceed the cost of construction. At a time when the Veterans Administration is being forced to tighten its belt, it is ludicrous to add a VA hospital at a site other than one which is fully justified by its capacity to serve the greatest number of veterans.

It is obvious that the Veterans Administration cannot justify the establishment of two new hospitals, one in Mobile and one at a Panhandle site. It is imperative for the many Panhandle veterans who desperately need a hospital within a reasonable driving distance that the individual veterans, the veterans organizations, the Veterans Administration and the Congress continue to work together to provide a hospital that will best serve the greatest number of veterans.

Statement

of

The Associated General Contractors of America

Submitted to

House Committee on Veterans Affairs

Hospitals and Health Care Subcommittee

U. S. House of Representatives

On the Topic of

Fiscal Year 1986 Budget Proposal for the Veterans Administrations' Construction Program

March 5, 1985

AGC is:

- More than 32,000 firms including 8,500 of America's leading general contracting firms responsible for the employment of 3,400,000-plus employees;
- 110 chapters nationwide;
- More than 80% of America's contract construction of commerical buildings, highways, industrial and municipal - utilities facilities;
- Over $100 billion of construction volume annually.

The Associated General Contractors of America

Statement

House Committee on Veterans Affairs

Hospitals and Health Care Subcommittee

U. S. House of Representatives

Fiscal Year 1986 Appropriations

Over the past two years the Associated General Contractors of America has testified many times before Congress to advocate the need to rebuild America's deteriorating infrastructure. AGC has surveyed existing studies and reports on infrastructure needs and contacted over 100 organizations, states, and cities in an effort to develop a documented estimate of necessary investment to meet presently identified infrastructure needs. The AGC research reveals a minimum necessary capital investment of approximately $3.03 trillion. At least $300 billion is required for public buildings alone.

No area of building infrastructure is of more critical concern than the deteriorating condition of the nation's hospitals and health care facilities, including those of the Veterans Administration. Growing numbers of U.S. veterans will call upon the VA to utilize its health services in the coming years. AGC supports a fully and adequately funded construction program for Veterans Administration hospitals and health care facilities to meet the VA's obligation to our veterans. AGC urges, for the reasons provided below, that the Congress fund VA construction

programs at levels higher than those requested by the Administration and at levels no lower than FY 1985.

The group of Veterans 65 or older, for whom the Veterans Administration is expected to provide medical services, grows daily. Demographic statistics indicated the aged veterans population will increase from 3.3 million in 1982 to 9.2 million in 1998. If current trends continue the number of VA nursing home beds will have to triple in 20 years from 40,000 to 120,000. But what about available care?

The quality of hospitals and health care facilities available to veterans, whether in private or public institutions, is rapidly deteriorating. A study in the early 1980s by the Department of Health and Human Services indicated that $130 billion of construction was necessary to replace obsolete health care facilities. However, in 1982 the nation was spending only 50% of the annual required amount to meet this need.

Another study conducted by the American Hospitals Association in 1982 underscored the deteriorating condition of our nation's hospitals including those operated by the federal government. The survey revealed 21.1 percent of all U. S. hospitals reported that more than 50 percent of their inpatient facilities are over 30 years old. Further, this figure more than doubles for federal hospitals. 46.5 percent of the federal hospitals reported that over 50 percent of their inpatient facilities are 30 or more years old.

The VA has commissioned a Capital Facilities Study to determine the current status, adequacy and total deficiencies of the physical plant. The objective is to define more precisely the total dollar needs to maintain its 172 medical centers, 104 nursing homes, 16 domiciliaries and various independent and satellite outpatient clinics. AGC expects the report will reinforce what other infrastructure studies have found and show that significant expenditures are necessary in the VA's construction program to meet growing veterans needs, as well as to do the basic maintenance and repair on existing facilities.

The construction program recommended for FY' 86 by this Administration for VA major construction is $417 million, for minor construction $194.4 million and $24.9 million for grants for related construction or renovation of State home facilities for veterans. Such funding levels are inadequate to address the serious infrastructure need of hospitals and health care facilities for our veterans. AGC urges Congress to fund an adequate building program to fulfill its obligations to our veterans.

○